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ABSTRACT

The Indiana statewide Acquired Immune Deficiency Syndrome (AIDS) prevention plan focuses on community education efforts targeted for specific high risk groups as well as health care and other professionals. Plans are summarized for dissemination of information to the following groups: risk groups, physicians, dental health, nursing, ancillary health care workers, emergency medical services personnel, long-term health care workers, university and school personnel, and correctional system personnel. Additional topics discussed include AIDS in the workplace, AIDS among black/minority populations, perinatal transmission of AIDS, support to local community efforts, reporting practices, and screening. Indiana's plans for treatment services are described, and approaches to reducing high-risk behavior are discussed. Appendices consisting of article reprints and copies of guidelines and regulations comprise over half the document. They include "AIDS on Campus: Emerging Issues for College and University Administrators," by Sheldon Elliot Steinbach; "Policy for School and Work Attendance by University Students or Employees with Acquired Immune Deficiency Syndrome," prepared by Dennis L. Madson; "Communicable Disease Regulation HCD-33, State of Indiana"; "Guidelines for Children with AIDS/ARC Attending School"; and definitions of AIDS and ARC (AIDS-Related Complex). (JW)

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INDIANA

AIDS PREVENTION PLAN

1986

INDIANA STATE BOARD OF HEALTH

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VERSION 1.0

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ATTACHMENTS

•Emergency Medical Services Guidelines

•University Policy Guidelines

•CDC AIDS/ARC Diagnostic Criteria

•Indiana State Communicable Disease Regulations

•CDC Prenatal and Perinatal Guidelines

•CDC Guidelines on AIDS in the Workplace

•ISBH School Attendance for AIDS/ARC Children

I. EXECUTIVE SUMMARY

A Statewide AIDS Prevention Plan demands coordination of multiple disciplines maintaining a unified message. Given the magnitude of the AIDS problems and in anticipation of effectively limiting the spread of this disease, these programs will be vigorously pursued.

Education is our most effective means of prevention. Efforts will be targeted for specific high-risk groups, as well as areas of potential occupational risk. In addition to specific risk groups, it is imperative that the general public receive current information pertinent to their fears and concerns. Health care workers will receive educational sessions through in-service programs, professional organizations and local/county health groups.

Community efforts are vital to the overall State AIDS Plan. Coordination of local task forces and interest groups provide additional resource centers and clearing houses for information of local interest.

The ISBH's Division of Chronic and Communicable Disease Control and the AIDS Education Office, assisted by the AIDS Advisory Commitee members, will continue to provide consultation for institutions/facilities relevant to the development of internal management policies. Such policies are vital to the accommodation of persons with AIDS in these settings.

The ISBH Division of Chronic and Communicable Disease Control assists in the provision of screening of HTLV-III carriers in the State. Alternate collection sites are available to provide antibody testing to high risk persons. Counseling to modify potential behavior risks is in integral part of this program.

Research is key to the development of a vaccine against the virus, as well as a cure for the disease itself. The ISBH feels it must remain abreast of groups actively supporting AIDS research, and will continue to provide information to Hoosiers as research results are released.

The approach to this multi-faceted problem will range from education and counseling to direct high risk behavior reduction efforts. Significant groundwork has been laid by numerous programs and continued efforts will be made to provide a successful Statewide AIDS Prevention Program in Indiana.

Because AIDS information is rapidly expanding, this document will remain fluid and in constant revision. As new information and recommendations become available, such changes will be incorporated and noted as follows:

> The initial document is to be designated (1.0). With each major revision, the indicator will increase one digit (2.0). For each minor revision, the indicator will increase one-tenth (1.1). Changes in text will be identified by a different style of type (i.e., bold, italics).

II. BACKGROUND

A. Epidemiology of AIDS in Indiana

The Acquired Immune Deficiency Syndrome (AIDS) appears to be a new disease in mankind. It appeared simultaneously in New York and San Francisco, and may have been there as early as 1979. The first case of AIDS in Indiana was identified in late 1982, shortly after the syndrome of AIDS was described by the CDC in Atlanta. Since that time, the number of cases in the U.S. has nearly doubled every six to nine months, to a total caseload of over 16,000. As of December 31, 1985, Indiana had 60 of these individuals, of whom 31 have already died. Should this rate continue, by 1990 there could be 800 cases in Indiana alone.

Three major high-risk groups were identified: homosexual/bisexual men, intravenous drug users, hemophiliacs and other blood products recipients. Although the numbers of individuals with the disease has rapidly increased nationally, the disease has remained largely confined to these groups. Hetrosexual men and women are at very low risk. They represent only 1% of the cases identified, with virus transmission occuring through intimate contact with

individuals infected with the virus. Through intensive study, the modes of spread have been identified as sexual contact, and blood to blood contact.

The agent of AIDS has now been identified as the HTLV-III virus. It attacks and destroys selected white blood cells causing a specific defect in the immune system which leaves the infected individual susceptible to opportunistic infections. A test to determine exposure to the virus has been developed. Of those exposed to the virus, it appears that one third will develop the full-blown AIDS syndrome which results in death. Others may develop lesser manifestations and some may have no symptoms at all. However, it is currently believed that exposed individuals will remain infected for the remainder of their lives, and are potentially infectious to others. Currently, less than 20% of Indiana individuals in high-risk groups have been exposed to the AIDS virus, compared to nearly 80 percent in New York and San Francisco. Moreover, the literature reports a rapid penetration of the virus, from 5% to 80% seropositivity in two years in some high risk populations. This data clearly emphasizes that Indiana is in a position where proper control measures can potentially limit the spread of the disease and save many lives, if immediately and vigorously pursued.

When the ELISA test for the HTLV-III virus became widely available in March, 1985, Indiana along with most other states moved rapidly to insure the safety of its blood supply by routine screening of donor blood. In addition, under a grant from the Centers for Disease Control, the Indiana State Board of Health has established nine sites around the State where HTLV-III tests can be performed on request, to help discourage those in high-risk groups from utilizing the blood banks to gain personal health information. However, much additional work remains to develop the full potential of HTLV-III testing programs to trigger epidemiologic casework and individual counseling to slow the transmission of the virus.

Other preventive modalities must also be explored in Indiana in 1986, as well as issues related to treatment, social services, and research. This Plan will attempt to map out the work at hand.

B. Coordinated Approach

Significant groundwork by numerous organizations and institutions throughout the State of Indiana has been completed.

* The State Board of Health has already heavily committed professional staff to public and professional education, to policy development consultation, to supporting local community organizational efforts statewide, and to epidemiologic services.

* Hospitals and long-term care facilities are revising their infection control procedures to protect patients and healthcare workers.

* School districts are studying educational alternatives for afflicted children.

* Universities have begun to address the educational and service needs of their student populations, and are involved in clinical research.

* The State Department of Corrections and local correctional and detention facilities have begun to educate staff and develop protective procedures.

* Professional organizations as well as groups of public employees, such as firemen and policemen, have begun to address occupational risks.

* Businesses are expressing concern regarding employee fears of exposure in the workplace.

* The insurance industry is wrestling with issues of insurability and cost of care.

* The legal community is beginning to ponder questions of confidentiality and patients' rights.

* The law enforcement community is reviewing current laws and ordinances which may be applicable in reducing high-risk behavior.

* The print and broadcast media are working very actively to promote public awareness of all of these activities.

It is vital that communication be established and maintained among all these groups of concerned citizens, so that replication of success, not duplication of efforts, results.

The Indiana State Board of Health is the natural lead entity in the areas of professional and public education, case-finding and epidemiologic services, as well as overall coordination of statewide efforts.

C. AIDS Advisory Committee

The AIDS Advisory Committee was formed in May, 1985, to help guide AIDS control activities at the State level, and provide important liaison between the State Board of Health and the organizations the members represent. These organizations include the State Board of Health, the Indiana University School of Medicine, Indiana State Medical Association, Academy of Pediatrics, Fort Wayne Regional Blood Center (Red Cross), Central Indiana Regional Blood Center, Indiana Public Health Association, Indiana Hospital Association, the Association of Practitioners in Infection Control, Indiana University Student Health Center, Bell-Flower STD Clinic, Association of Public Health Physicians, Justice, Inc., Indiana University School of Dentistry, Indiana State Nurses Association, Indiana Department of Mental Health, and the insurance industry.

To date this advisory group has been significantly involved in development of the ISBH Guidelines for Children with AIDS/ARC Attending School. Some other issues addressed have included education as a tool in prevention and control of AIDS, policy for nursing home placement of AIDS patients, and the strategy for optimum use of the HTLV-III antibody tests.

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III. EDUCATION

A. Overview of the ISBH AIDS Education Program

In the midst of ever-increasing public anxiety fueled by daily reports of new AIDS cases, one simple fact stands out: THE GENERAL PUBLIC MUST LEARN ABOUT AIDS. Education concerning transmission and prevention has become particularly important because AIDS is a new disease and carries an extremely high fatality rate. It is also primarily transmitted by human behaviors which are difficult for individuals to modify.

The ISBH response to the educational need has been based upon networking of resources, and placing emphasis on public forums tailored to target audiences' educational levels and needs. Over 6,500 people have received direct presentations since the formation of the AIDS Education Office in September, of 1985.

Demands from across the State have resulted in distribution of over 15,000 pamphlets and 30,000 more to meet immediate requests.

Development of an educational videotape will make it possible to reach the State with a direct and uniform message. The goal is to place this videotape in most libraries across the State in 1986.

An AIDS Awareness Week (January 13-17) will open the 1986 public education campaign to focus the public's attention on the modes of transmission and methods of prevention. Numerous forums, seminars, telecommunication programs, and media coverage will extend the message to large numbers of the general and professional public.

Universities, churches, and civic groups will be targeted for extensive effort in 1986, in response to pending requests from these types of organizations.

Programs have been given and will be supplemented during 1986 to school nurses, teachers, correctional staff, EMTs, law enforcement agencies, industries, gay organizations, and insurance companies upon request (see specific sections following.)

It must be emphasized that "one-shot" coverage of the State is insufficient to change deeply held attitudes, feelings, fears, and established behaviors. Furthermore, as the information changes, new developments in our understanding of the nature, transmission, and prevention of this alarming disease must be effectively communicated to as wide an audience as possible. Hence, the ISBH AIDS Education Office does not anticipate a decrease in public demands for its services in the foreseeable future.

B. Special Target Groups

With its present resources the ISBH AIDS Education Program cannot direct educational programming to all Indiana citizens, although no requests will be categorically refused. The education and training of intermediaries will be the principal approach to comprehensiveness in public education in 1986, and will be of direct benefit to those professionals who may eventually live and work with affected citizens.

1. Risk Groups

Carefully planned, culturally sensitive education programs for those at high risk will be emphasized in 1986. Efforts will be coordinated with public, private, and voluntary organizations.

Educational support and consultation will be offered to the gay community. Concerns have been expressed by gay community representatives about individual rights, including confidentiality of medical information and employability and insurability issues. Additional effort will be made to build and maintain communication lines essential to promoting an effective educational process in

this most heavily affected of all risk groups. It must be noted that significant educational efforts have been underway for some time within the gay community itself, and ISBH has recently provided direct support to the production of culturally sensitive printed materials. It is hoped that the gay community will continue to provide a major educational effort with gay citizens, given the importance of source credibility to effective communication of health information. The ISBH will continue to be helpful in promoting education directed toward behavior change, and will continue to provide accurate, current medical information about the transmission and prevention of AIDS.

Further, hemophilia-related organizations and drug abuse centers will be provided with epidemiologic information to be translated into meaningful prevention information, and health and social service professionals will be offered ongoing consultation on how to educate persons who may be infectious or at risk of infection.

2. Physicians

The ISBH will continue to respond to requests to provide speakers for local medical society and hospital staff meetings. ISBH staff physicians will continue to be available to provide consultation and answer questions from individual physicians by telephone.

The Indiana Epidemiology Report, a monthly newsletter sent to all physicians in Indiana, and the State Health Commissioner's page in the ISMA Journal, Indiana Medicine, will continue to be used to disseminate information on AIDS to the physician. If resources allow, consideration will be given to initiating a monthly newsletter, devoted entirely to AIDS, to be mailed to physicians and other health professionals in Indiana.

3. Dental Health

On the evening of January 14, 1986, the Dental Division of the ISBH, in cooperation with the Indiana University School of Dentistry and Indiana Dental Association, will present a telecommunication program to the dental profession in Indiana on AIDS and infection control in the dental office. It is anticipated that the majority of the 3,100 dentists in the State will arrange to view it at one of 14 telecom sites throughout Indiana. The 90-minute program features professional staff members from ISBH and IU School Schools of Medicine and Dentistry, and discussions will center heavily on new barrier techniques. Doctor Myers will keynote the program and Dr. Vic Mercer, Director of the ISBH Dental Division will host the program, which will be carried over the State University's Continuing Education Network and the I.U. Medical School Television Network. The ISBH, as lead agency, will promote video in other states. Interest in the tapes has already been expressed by CDC and the U.S. Armed Forces.

The ISBH Dental Division is also preparing a pamphlet called, "The State Board of Health and Your Dentist Want You to Know", for dental patients and the public stating dentistry's involvement in infection control. This pamphlet will explain to patients the importance of barrier procedures in the dental office to protect all patients, and will further stimulate the dental profession to practice office asepsis.

In coordination with the pamphlet, the Dental Division is preparing an exhibit to reach dental and allied health professionals. There are currently 15-20 occasions a year in which such an exhibit can be employed. A slide/tape presentation on AIDS is also being prepared, and a resume of oral involvement in AIDS and other conditions which pose special care problems.

4. Nursing

Nursing education programs on AIDS are currently being offered throughout the State by Martha Deardorff, Division of Nursing, Indidna State Board of Health. These programs are designed to address the many concerns of nurses, and are locally available upon request.

Topics covered in these educational offerings include: curent information about AIDS, including its natural history, transmission, high-risk groups, national and local trends, signs and symptoms, and modes of prevention. Detailed information is given regarding the importance of the HTLV-III test and its value, infection control precautions, and the psychosocial aspects of the disease.

Ten seminars have been presented throughout the State with approximately 600 nurses attending. Various clinical settings were represented, namely, school, public health, hospital, home health, and mental health.

Plans for the future include an additional 11 programs. Locations for these programs are in Marion (2), St. Joseph, Lake, Noble, Grant, Wayne, and Howard Counties. A joint program is scheduled in Cincinnati, Ohio, in April, 1986, for Indiana and Ohio nurses.

In order to reach a large population of nurses, program information has been mailed to nursing administrators in schools, public health departments, hospitals, and mental health centers. Plans to send mailings to nursing homes, home health agencies, occupational health, and other community agencies employing nurses are being made. Many myths and fears about AIDS have been dispelled following these programs as reported by the nurses.

The ISNA (Indiana State Nurses' Association), and APIC of Indiana (Association of Practitioners in Infection Control) have also been involved with the ISBH in educating nurses about AIDS. Bulletins that are distributed to the membership of ISNA have contained three articles on the topic of AIDS. District four of ISNA,

in conjunction with APIC and ISBH, presented a seminar in Evansville. Approximately 100 nurses attended this program. Topics at the program were risk factors, transmission, prevention, and precaution. Additional conferences on AIDS were sponsored by ISBH and APIC of Indiana and were presented in Indianapolis, Fort Wayne, and Bloomington to nurses. APIC and ISBH made two AIDS video tapes in 1984, and shared these tapes with hospitals throughout Indiana for use with physicians, nurses and hospital personnel.

For 1986, another AIDS conference will be presented by APIC nurses to other nursing groups upon request. Currently the critical care nursing groups have requested from APIC of Indiana an AIDS program for January, 1986. The ISBH plans to have the topic of AIDS presented in the October 1986, ISNA clinical session program.

Finally, a teleconference for community care nurses and all hospital personnel is scheduled for the latter part of January. The sponsoring agency is the Americal Hospital Association, Department of Infection Control.

5. Ancillary Health Care Workers

The Centers for Disease Control has published simple, reasonable infection control guidelines for the protection and reassurance of clinical laboratory personnel, as well as dietary, laundry, and housekeeping personnel in health care and other institutional settings. While the majority of these educational needs are being met by the institutions themselves, ISBH has provided, and will continue to provide, direct programming and/or training-for-trainers and consultation on request, using the CDC materials.

6. Emergency Medical Services Personnel

The appearance of AIDS as a blood-borne disease has raised concerns about infection control in the Emergency Medical Service community. The nature of the work of EMS personnel often requires close contact with patient's blood or body secretions under conditions which are not ideal for infection control. In addition, the patient's illnesses are often not known.

The Indiana State Board of Health has worked closely with the Indiana State Emergency Medical Service Commission to develop guidelines to reduce the risk of infection to the EMS personnel and to their patients while maintaining quick and efficient emergency medical services. (See Attachments) These guidelines were presented to the EMS commission by Doctor Myers on December 12, and approved as written. The commission will forward these guidelines to EMS providers for implementation, and the ISBH will provide further consultation as requested in 1986.

A residual issue which poses potential implementation problems is how to provide feedback to EMS personnel when patients transported by EMS personnel are found to be seropositive for HTLV-III in the hospital. The confidentiality problem will need to be explored with hospitals and physicians, and the ISBH will provide consultation as requested.

7. Long-Term Health Care Workers

The nursing home industry will shortly receive from the American Health Care Association a model policy and procedure manual, and information of a general nature on AIDS and the care of AIDS patients. The major trade associations in Indiana already have plans throughout the State, and the ISBH will provide assistance with direct programming and/or training-for-trainers and consultation on request in 1986.

In November, ISBH staff met with industry representatives to establish guidelines for the admission of AIDS patients to long-term care facilities. Such guidelines are needed to meet the requirement of the Indiana Health Facilities Council that admissions of all patients with active communicable diseases have prior approval by the Council. These guidelines will require that a facility request management staff in the Division of Health Facilities to review proposed admissions case-by-case to insure the suitability of facilities to provide acceptable care for these patients. The guidelines will include not only patients with diagnoses of AIDS but also those with ARC and with true positive HTLV-III test results, irrespective of clinical diagnosis. The guidelines will further specify that ISBH staff may make a special inspection to insure that a recent history of acceptable infection control practices is being maintained. The guidelines will also address the confidentiality of patient records, and of the facilities themselves which accept AIDS/ARC/seropositive patients.

8. University Personnel

The American College Health Association released in December a model policy statement for the accommodation of AIDS patients in the university setting. At least one university on the East Coast has implemented a policy based on this document. Both documents are attached (see Attachments) and are available through the Indiana State Board of Health to assist institutions of higher learning throughout the State in addressing these issues within their own walls. At least one university in Indiana is presently reviewing these documents. The report will be provided to all colleges and universities in the State of Indiana after review by the Statewide AIDS Advisory Committee.

The documents emphasize that the primary response of educational institutions must be education to prevent transmission; that educational efforts should include

students, faculty, and staff, and should be given "the highest priority." They emphasize that casual contact is not a mode of transmission of the AIDS virus, and that the presence of infected persons in normal classroom and dormitory settings is easily accomodated and not a mode of transmission of the AIDS virus. In addition, college health service physicians should coordinate with the private physicians caring for affected students to insure the well-being of these students on campus, and to protect their confidentiality.

9. School Personnel

The school guidelines developed by the ISBH in July, 1985 will be updated in 1986. A subcommittee of the AIDS Advisory Committee will be designated to work in consultation with medical staff from IUMC, with staff from the Department of Education, and with school nurses to accomplish this revision.

ISBH Division of Nursing has provided direct education to school nurses, and will continue this work in 1986.

In addition, ISBH AIDS Program staff have requests from school administrative personnel to consult in their districts, and are heavily scheduled in the schools in February, 1986.

10. Correctional System Personnel

In November the Indiana Department of Corrections formulated a document called "Departmental Procedures for AIDS" to meet the needs of the incarcerated population and of correctional facilities staff with respect to AIDS prevention and the management of prisoners with AIDS. Some important decisions were incorporated within the policy:

A. A single facility was designated to house all offenders with AIDS diagnoses.

B. Testing is made available to high-risk persons upon request, or persons with symptoms suggestive of AIDS, however, no blanket policy was established or planned to test offenders for the HTLV-III virus.

C. The ISBH will provide educational programs to DOC staff. Each facility will have staff from several departments trained to educate other about AIDS. Through these trainers, other staff and offenders will be reached.

These programs have begun, and will continue to be provided upon request of the DOC in 1986, to insure currency of information. Additionally, ISBH physicians will continue to consult with DOC management, if revision of this working policy is necessary. The Centers for Disease Control is expected to release guidelines concerning correctional facilities in the near future.

11. AIDS in the Workplace

With increasing public concern about the spread of AIDS, the issues of AIDS and the HTLV-III virus in the workplace is a major topic. Non-sexual, person-to-person contact occurring among workers, clients and customers in the workplace is not known to pose a risk for transmission of HTLV-III. The Indiana State Board of health AIDS Education Program has received numerous requests from businesses for printed literature to be included in payroll envelopes. Discussions have been initiated with an area business corporation to pursue a joint marketing campaign and promotion of corporate giving to support AIDS research in Indiana. Education opportunities for employees in non-health care settings through in-house and/or trade publications will be explored.

The ISBH is available for consultation in the development of internal policies concerning personnel issues (hiring, insurability, sick leave, etc.). Management of the public relations impact of employing a person infected with HTLV-III should also be addressed by employers, and ISBH may be able to provide consultation via its commission on Health Marketing.

12. Black/Minority Groups

To date AIDS has been primarily associated in the public mind with white male homosexuals; it has not been perceived as a disease of Black/Minority groups. However, the Centers for Disease Control report that 25 percent of the 16,000 AIDS patients reported nationwide are Black, and in New York, over 55 percent are ethnic minorities. Approximately one-half of children with AIDS nationwide are Black. In Black and Minority communities there is less public awareness of the penetration of the HTLV-III virus into the heterosexual population through IV drug abuse, and through past therapeutic receipt of blood and blood products.

There is an urgent need for education of Black/Minority communities on AIDS, especially in the IV drug abuser sub-population.

In 1986, ISBH will include targeted education on AIDS to Black/Minority communities in Indiana.

13. Perinatal Transmission of AIDS

A major part of the battle against AIDS includes testing women in high risk groups for the HTLV-III virus and counseling them to delay pregnancy.

Informing and educating young women at risk for AIDS is the best weapon against perinatal transmission. In addition, health care providers need information to help manage the pregnancies of women infected with the virus. Guidelines have been established and

recommendations issued by CDC for assisting in the prevention of perinatal transmission of the HTLV-III virus. (See Attached.) The Maternal and Child Health Prenatal Care programs will help implement these guidelines for high-risk women throughout the State.

C. Support to Local Community Efforts

With advice and participation by ISBH AIDS Education Office staff, community AIDS advisory committees have been organized in several communities around the State. ISBH staff are committed to vigorous promotion of local prevention efforts in 1986, with the involvement of local health officers, local health care and educational institutions, and voluntary organizations. It is our belief that a superior prevention effort depends on its specificity to local problems and priorities, across all prevention modalities. By using the ISBH AIDS Education Office and medical staff of the Division of Chronic and Communicable Disease as central nodes in the statewide network, local community advisory groups can assure that replication of success, not duplication of effort, results.

In a recent letter to all local health officers in the State, Doctor Myers asked for their immediate participation in leading the fight against AIDS. Specifically, he requested that they promote local participation in AIDS Awareness Week, January 13-17, by organizing educational events in their communities during that week, and offered the ISBH AIDS Education Office staff as advisors. Continuous, vigorous local leadership and networking by location, as well as by profession and by organization, will increase the scope and effectiveness of our statewide assault on AIDS.

IV. POLICY DEVELOPMENT

There are a number of common issues facing institutions in developing their specific policies and procedures. Emphasis on the lack of known risk in casual contact, and basic infection control practices are desirable, and can be uniform in a number of different settings. Issues relative to individual rights, and the need to preserve the confidentiality of medical and other records need to be addressed in a uniform manner to the extent possible.

There are also significant differences which must be reflected in an institution's approach to AIDS patients and/or true seropositive individuals within their walls. For example, the higher seropositivity rate among offenders in correctional institutions, due to the high proportion of drug abusers relative to the general population, and the high incidence of homosexual contact in prisons, all make the prevention of viral transmission especially problematic. At the same time, the risks to individual offenders of breaches of confidentiality may be more immediate and direct than in the general population, secondary to confinement, and to the propensity for physical violence within the incarcerated population.

ISBH's Division of Chronic and Communicable Disease and the AIDS Education Office staff, assisted by AIDS Advisory Committee members, will continue to provide consultation in 1986 to schools, health facilities, prisons, and other institutions regarding admission policies, appropriate levels of infection control, internal education efforts, and other issues related to the accommodation of persons with AIDS in these settings. Additional areas are already being identified in which ISBH consultation will be made available to those charged with policy development, for example, AIDS and organ transplantation and AIDS in mental health institutions. Other problem areas are certain to be identified in 1986. Because the ISBH is a clearinghouse for model work in other states, as well as for current recommendations from the CDC, the need for consultation by the State Board of Health is not likely to decrease in 1986.

V. REPORTING OF AIDS/ARC

Acquired Immune Deficiency Syndrome (AIDS) and AIDS-related Complex (ARC) will be added to the list of reportable diseases found in the Indiana State Board of Health Communicable Disease Control Rule 410 IAC 1-2. Pending promulgation of the amended rule, physicians and hospitals are required to report AIDS and ARC under the general provision of 410 IAC 1-2-2(b) which requires reporting of "other communicable diseases which are not prevalent in Indiana but are dangerous to the public health when they do occur..." AIDS and ARC should be reported in the same manner as other "Diseases Reportable by Name," such as hepatitis or meningitis. Attached to this Plan are the current diagnostic criteria used by the Centers for Disease Control for the diagnosis of AIDS and ARC, as well as relevant sections of the State Communicable Disease Regulations. (See Attachment)

The ISBH feels that statistical reporting without personal identifiers of true seropositives, for the purposes of monitoring seroprevalance by area, is central to ongoing planning of prevention strategies and resource allocation. The provision of personal identifying data is not necessary to this activity, however, and will not be required in the foreseeable future. In early 1986, the ISBH will initiate discussions with clinical laboratories, free-standing and hospital-based, as well as with CDC to develop the necessary data set, confidential reporting procedures, and a time frame for implementation.

VI. FIELD SERVICES

Nine Alternate Collection Sites were established in April 1985, to provide locations where HTLV-III screening would be available to high-risk persons. The laboratory work is performed by the State Board of Health. It is expected that the role of these sites will expand in 1986 with the promotion of more widespread screening of high risk groups.

Screening tests will be offered, in Alternate Sites and other locations, to any men that have sexual relations with other men, persons with hemophilia, intra-venous drug abusers and other individuals who share needles, sex contacts of risk group members and those known or suspected to be infected with HTLV-III, persons attending drug

abuse detoxification centers, clientele of sexually transmitted disease clinics, high risk mothers attending prenatal-perinatal clinics, and others having known or possible increased risk. Screening of blood donated at blood and plasma centers will continue.

Expanded screening activities will correspondingly increase the need for trained counselors. In addition, contact tracing, similar to procedures employed for decades in control of syphilis and gonorrhea, is likely to become an important tool. Persons infected with HTLV-III must be assumed to be infectious and the majority are asymptomatic. Therefore, AIDS will never be controlled until a substantial proportion of such persons, and their sexual or needle-sharing contacts can be identified and effectively counseled, or until an effective vaccine is developed.

Many experts predict that for each individual identified with AIDS, there are 100 individuals in that population who are positive for the HTLV-III antibody. We expect, therefore, that approximately 6,000 Hoosiers are currently antibody-positive for the HTLV-III virus. Proper contact tracing of this number of individuals throughout the State, many of whom remain unidentified, would be an enormous and an expensive task.

The number of AIDS cases in Indiana, and across the United States is expected to double every nine to twelve months for at least the next two to three years, therefore, the number of individuals who become antibody-positive for the HTLV-III virus will also double. Although we strongly believe that education and prevention counseling are appropriate and worthwhile, documented efficacy of this approach with the HTLV-III virus is not currently available. Education and prevention, however, are the only available public health strategies. Contact tracing, although desirable, and a proven public health practice for other diseases, is a labor and resource intensive approach.

The ISBH continually struggles with the delimma of how to balance our commitment of resources to AIDS-related activity versus the resource requirements of other serious disease control programs. Therefore, until the positive effect of contact tracing is adequately documented, and until the resources necessary are available, we must target our primary efforts towards broad, identifiable populations, especially those at high risk.

Although public health agencies have an excellent record of maintaining confidentiality of records, some risk group members remain concerned that information could fall into the wrong hands. Consequently, much of the screening now done is performed anonymously. Anonymous screening will remain necessary in order to attract sufficient numbers of risk group members to screening sites. There must be greater emphasis on counseling those with positive results so that they voluntarily notify and refer their own contacts. Concerns about confidentiality of records will continue to hamper these efforts until Indiana's high risk populations feel secure that safeguards are adequate. The ISBH will take steps to assure that all health department records relating to HTLV-III infection (and other STDs and infectious disease) continue to be protected from inadvertant disclosure, or any other disclosure not agreed to by the patient.

VII. TREATMENT SERVICES

It is essential from both a humane standpoint and a cost standpoint that AIDS patients in the State of Indiana have available to them a full range of medical, dental, and psychosocial supportive care in inpatient, outpatient, home care, and hospice programs. In 1986, ISBH will collaborate with IUMC and other hospitals around the State, with gay organizations, with the APIC Task force on AIDS, and with other involved organizations to promote a full spectrum of services, and statewide access. Planned are a Directory of AIDS Care Services, which will serve both to facilitate referral and to assist in identifying gaps in services by area. Telephone referral is already a daily activity of ISBH AIDS staff, and will continue in 1986.

One goal of this service mapping and referral is to make available to citizens of the State who are afflicted with AIDS the opportunity to be enrolled in experimental treatment protocol programs as promising new therapeutic agents become available.

Further, ISBH will address issues related to funding for care at all levels. Staff will continue to disseminate up-to-date information on number and distribution of cases, and projected cases to the extent possible, in order to assist third-party payors, the Department of Public Welfare, and township trustees around the State in planning for adequate reimbursement for care of AIDS patients.

ISBH will also work through statewide organizations and with individual health care facilities to insure placement of individual patients at the least costly level of care which meets the patient's needs.

The Indiana University Medical Center has established a task-force, with ISBH participation, to study and plan those services desirable for AIDS/ARC patients at the IU Hospital and Wishard Hospital. It is expected that these plans will be finalized and implemented in 1986.

VIII. REDUCTION OF HIGH-RISK BEHAVIOR

The ISBH will continue to strongly discourage behaviors which are known to promote the transmission of the HTLV-III virus between humans. The following high-risk behaviors, are known to promote transmission of the HTLV-III virus from an infected individual to a non-infected individual:

- Sexual acts without the use of condoms or modifications which preclude mucosal contact with blood or semen. Such acts include vaginal, rectal and oral intercourse.

- Sexual practices which result in blood or semen contact with traumatized rectal mucosa.

- Sexual contact with individuals whose identity and/or other sexual partners are unknown.

- Sexual contact with multiple sexual partners.

- Intravenous injection of drugs, or any other substance using a non-sterile needle.

This does not include the universe of high-risk behavior, nor does it include all virus transmission opportunities. The above list does outline those behaviors that are known to occur between high-risk individuals that have been documented to substantially increase transmission of the HTLV-III virus.

Education, while basic to prevention, is not the only approach that must be utilized. For those individuals who are unresponsive to either information on AIDS or the individualized counseling possible in epidemiological casework, as demonstrated by continued irresponsible behavior, other options must be pursued. Restriction of movement and/or isolation may be necessary for individuals whose irresponsible behaviors continue to endanger the health of others. Such action is the responsibility of local health officers and the State Health Commissioner and is mandated by and described in Indiana statutes. Such action will be initiated on a case-by-case basis as necessary, after voluntary efforts and less severe options have not proven successful. The State Health Commissioner will consult with local health officers and other appropriate individuals when those are identified whose behavior with respect to transmission of the HTLV-III virus puts other individuals at risk. If voluntary and conservative measures are unsuccessful, and if a local health officer is unable to act or fails to act to protect the public's health, the State Health Commissioner will utilize appropriate measures authorized by statute.

Businesses, establishments, or facilities which in whole or in part provide opportunities for, or otherwise promote and facilitate high-risk behavior on their premises must be identified throughout Indiana without delay. If these entities fail to voluntarily and effectively prohibit those activities which facilitate transmission of the HTLV-III virus local and state public health officials will take appropriate legal action to regulate their operation in such a way as to eliminate the high-risk behavior. Each entity will be evaluated on a case-by-case basis in conjunction with the local authorities.

The State Board of Health is hopeful that the necessity to utilize full statutory powers is rare. The actions described above are consistant with the current recommendations of the Centers for Disease Control and the Association of State and Territorial Health Officers.

IX. RESEARCH

National AIDS-related organizations are seeking to involve private citizens and corporations in the funding of research on AIDS. Research is key to the development of a vaccine against the virus, as well as a cure for the disease itself. ISBH will remain abreast of groups actively supporting AIDS research, so that interested Hoosiers may be referred, should they desire to contribute.

The faculty of the School of Medicine - The School of Dentistry at the IU Medical Center are currently evaluating the experimental treatment protocols to pursue for AIDS/ARC patients at the Medical Center.

X. FOUNDATION SUPPORT

The American Foundation for AIDS Research (AFAR) was recently established as a national organization by merger of the AIDS Medical Foundation (New York) and the National AIDS Research Foundation (Los Angeles). Supported by many public personalities, such as Elizabeth Taylor, the group is based in Los Angeles and seeks to provide funding for AIDS research through private donations. It is not possible through AFAR to specify that donated funds be designated for use in Indiana.

The Federation of AIDS-Related Councils is involved primarily in lobbying activities to increase federal funding of AIDS research. Based in Washington, DC, the group is financially supported by a variety of AIDS-related groups around the nations.

At this time, there are no local foundations to which individuals/corporations may donate private funds to support the AIDS control efforts. The Bag Ladies, Inc., an Indianapolis-based organization, has established a community referral program through which donated monies may may be disbursed to local AIDS patients/families in financial need. The Bag Ladies also sponsors a newly-organized "Buddy Program" which assigns a trained volunteer to an AIDS patient for emotional support and help with everyday activities like shopping, cleaning, and laundry. This type of support service has proven very successful in San Francisco, which has a large number of AIDS patients living in the community at any given time between hospitalizations.

In 1986, the ISBH will continue to investigate the feasibility of the establishment of a local foundation to support research and other activities related to AIDS.

XI. AIDS AND MENTAL HEALTH

Numerous treatments of the AIDS problem in the popular media and professional literature have highlighted for us the tragic impact of the AIDS diagnosis on the personal and social lives of AIDS victims and their families.

In 1986, ISBH will seek to initiate a cooperative effort with the Indiana Department of Mental Health to promote the involvement of mental health professionals around the State in AIDS prevention and treatment efforts. A representative of DMH will be sought for the AIDS Advisory Committee, and DMH participation on the Indiana University AIDS Task-Force would also be desirable.

A full review of the contribution that local mental health centers can make to the lives of AIDS patients and their families will be requested, as well as a review of current and potential research, both in Indiana and around the nation on the mental health impact of AIDS.

Through the cooperation with DMH, other mental health organizations, and individual mental health service providers, ISBH will seek a better understanding of how our AIDS Education and Prevention efforts affect the mental and emotional state of AIDS patients, high-risk groups, health care providers, and of the general public.

12-85

STATE OF INDIANA

STATE BOARD OF HEALTH

AN EQUAL OPPORTUNITY EMPLOYER

INDIANAPOLIS

Address Reply to:
Indiana State Board of Health
1330 West Michigan Street
P. O. Box 1964
Indianapolis, IN 46206-1964

Recommendations for Communicable Disease Control in the EMS Pre-Hospital Setting

The recent appearance of AIDS has sparked a renewed interest in infection control. Because of nature of the work of EMS personnel often requires close contact with their patient's blood and body secretions, these guidelines have been developed to protect EMS personnel as well as their patients against not only AIDS but other communicable diseases as well. These represent prudent practices and should be used routinely.

During an emergency response one should:

1. Wear gloves to (A) prevent injuries to yourself which may result in bleeding. Fresh wounds to EMS personnel are most susecptible to infection through contamination. (B) prevent skin contact with the patient's blood or body secretions. In addition, open sores should be covered.

2. Dispose of needles and sharp instruments properly. Place them in a puncture resistant container immediately after use. Do not bend, break or recap them as this is one of the most common causes of blood exposure to health care workers.

3. Use a pocket mask for ventilatory resuscitation. Not only does it reduce the liklihood of your exposure to the patient's secretions, but it also provides better oxygenation to the patient.

4. Face masks should be worn whenever the patient's condition suggests a lung infection, such as tuberculosis, or whenever you have an upper respiratory infection yourself.

5. Should your skin or mucous membranes become exposed to the patient's blood or other body fluids, it should be washed off with water as soon as practical and the skin surfaces wiped with an antiseptic. This action will limit the length of your exposure to any potential pathogens.

Once the care of the patient has been transferred to hospital or other personnel, the following should be done:

1. All towels and sheets used in the response should be placed in a plastic bag for proper laundering.

2. Bandages and other one-time use items used in the response should be placed in a plastic bag and disposed of properly.

3. Clothing of the EMS personnel which has become grossly contaminated with blood or body fluids should be exchanged for clean fresh clothing.

4. The litter and contaminated inside surfaces of the transport vehicle should be cleaned with detergent and then wiped with a 1:10 dilution of household bleach.

5. Wash hands. This is the most effective means of infection control.

6. Accidential injuries resulting in exposure, such as cuts or needlesticks, should be recorded. This information should be used to develop guidelines to reduce the occurence of these incidences. It will also provide a base for follow-up when guidelines to investigate the status of the source patient are developed with the hospitals.

These guidelines are intended to provide the best possible infection control for EMS personnel without interfering with the quick and efficient provision of emergency medical services.

AMERICAN - COLLEGE
HEALTH - ASSOCIATION

December 2, 1985

Dear Colleague:

Enclosed are three important documents concerning the response of colleges and universities to the Acquired Immunodeficiency Syndrome (AIDS). They are:

1. A copy of the new **ACHA educational brochure** on AIDS, "AIDS—What Everyone Should Know." The Task Force on AIDS has revised the brochure to include current information and recommendations; the change in its title reflects the fact that the whole college and university population — students and employees — must learn about AIDS. An order form for securing copies of the brochure is also enclosed.

2. A **General Statement** prepared by the Task Force on AIDS concerning the institutional response to AIDS. This statement amplifies the Preliminary Statement issued at the end of September and addresses a great many new issues. It includes information about the responsibility that colleges and universities have to educate, and emphasizes certain important points of policy development.

3. A **white paper** prepared by the American Council on Education concerning the legal issues and obligations raised by AIDS. A close working relationship between ACHA and ACE has been critical to the development of both statements, and we feel that this legal paper capably addresses the major problems that college and university health officers and administrators must deal with in formulating responses to the AIDS crisis.

The Task Force on AIDS has worked hard to produce this statement, based on the best medical and scientific information currently available. It is provided in the spirit of suggested guidelines; all institutions are encouraged to seriously consider the need for extensive education programs and careful policy construction. We must be mindful that decisions made in haste or motivated by popular fear and anxiety about AIDS are likely to be regretted later.

Several Task Force working groups are currently preparing detailed discussion papers on the most important and difficult issues addressed in the General Statement: residential housing, confidentiality of information, educational priorities, testing and counseling issues, contact sports, employee education, and clinical procedures. A series of meetings in Washington, San Francisco, and the Midwest —all scheduled before the middle of December —will bring those projects toward completion. We anticipate mailing the resulting documents by the beginning of the second semester.

We appreciate the extensive feedback we have received during this process; please continue to keep us posted about what is going on at your school, so that we can keep our statements as relevant and complete as possible.

With our best wishes for a happy and peaceful holiday season.

Richard P. Keeling, M.D.
Chairman,
Task Force on AIDS

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AMERICAN - COLLEGE
HEALTH - ASSOCIATION

TASK FORCE ON THE ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

General Statement on Institutional Response to AIDS

December 2, 1985

The recommendations and guidelines included in this Statement augment and extend those of the Preliminary Statement on Disease Transmission issued by the American College Health Association (ACHA) on September 25, 1985. They are based on the best currently available medical information and on recommendations of the Public Health Service and the Centers for Disease Control. As indicated herein, ACHA will make available more detailed guidelines and information in certain specific areas of concern to colleges and universities in a series of reports and statements to be released in the near future.

The American College Health Association acknowledges the valuable assistance of the American Council on Education in the development of guidelines pertaining to the legal issues and questions presented by AIDS.

The primary response of colleges and universities to the AIDS epidemic must be education. Because there is no specific therapy for AIDS or AIDS-related conditions, the most important goals for institutions will be those of increasing awareness and providing education to prevent further spread of the disease. The American College Health Association recommends that the organization and completion of effective educational programs about AIDS be an activity of the highest priority for all institutions of higher learning. Such programs must address not only undergraduate students, but also graduate and professional students; they must reach not only residential students, but also commuters. Educational programs about AIDS should also be available to students in junior and community colleges and in programs of continuing education. Furthermore, universities and colleges should provide AIDS education for institutional employees, faculty, and staff.

Such educational programs will address the major intervention currently possible in limiting the consequences of AIDS, which is *primary prevention*. They may also be of paramount importance in discharging the institution's responsibility to protect its student body and staff from the transmission of AIDS. Since the current medical evidence indicates that no actual safety risks are created in a normal academic or employment setting, the administration of effective AIDS education and training programs provides the best way for institutions to render enrollment or employment safe and healthful. The AIDS epidemic raises issues of liability that are of great concern to college and university administrators; the most effective means of addressing these issues at present is to educate students and employees about AIDS and to take reasonable precautions such as are suggested herein.

In order for educational programs to be effective, they must provide current information, use reliable, up-to-date materials, and be widely available. The Task Force on AIDS of the American College Health Association has revised the organization's educational brochure on AIDS and is distributing it to all institutions. Detailed recommendations for educational programming, including suggested formats and methodologies, will be forthcoming from the Task Force shortly.

The American College Health Association recommends that institutions not adopt blanket policies concerning students with AIDS or AIDS-related conditions. Instead, it suggests that certain guidelines be followed and that the institution analyze and respond to each case as required by its own particular facts. Recommended guidelines are included in this Statement and in subsequent statements by the Association. Colleges and universities will benefit from the maintenance of as much flexibility as possible in dealing with the issues AIDS raises; given the uncertain legal obligations and challenges involved, institutions are advised not to devise and implement detailed policies at this time. However, it seems appropriate for college and university officials to identify and designate a person, group, or department to assume a managerial role in providing consistent and reasonable analysis of each case.

Guidelines for institutions derive from the best currently available medical facts about AIDS. Recommendations apply to all students or employees who are known to be infected with the virus thought to cause AIDS, Human T-Lymphotropic Virus, type III (HTLV-III); this includes those who have a condition meeting the surveillance definition of AIDS itself, those who have one of the lesser manifestations of infection (AIDS-Related Complex, or ARC), and those who are currently healthy but have evidence by the presence of a serum antibody to HTLV-III of exposure to and infection by the virus.

Current knowledge indicates that students or employees with AIDS, ARC, or a positive HTLV-III antibody test do not pose a health risk to other students or employees in an academic setting. AIDS is thought to be transmitted by intimate sexual contact or by exposure to contaminated blood. Although HTLV-III can be found in many body secretions of those who are infected, its presence there is not necessarily correlated with disease transmission by those fluids. There has been no confirmed case of transmission of AIDS by any household, school, or other casual contact. **The Public Health Service states that there is *no risk* created by living in the same house as an infected person; caring for an AIDS patient; eating food handled by an infected person; being coughed or sneezed upon by an infected person; casual kissing; or swimming in a pool with an infected person.**

These facts, derived from the best epidemiologic data currently available, are the basis for the following guidelines recommended by the American College Health Association.

1. Most college and university students who have AIDS, ARC, or a positive HTLV-III antibody test, whether they are symptomatic or not, should be allowed regular classroom attendance in an unrestricted manner as long as they are physically able to attend classes. See also Recommendation #12.
2. There is no medical justification for restricting the access of students with AIDS, ARC, or a positive HTLV-III antibody test to student unions, theatres, restaurants, cafeterias, snack bars, gymnasiums, swimming pools, recreational facilities, or other common areas. The ACHA is developing a statement that addresses such specific concerns as contact sports.
3. In the program of education that the institution provides, it should emphasize the following recommendations of the Public Health Service:

   a. Even though they may be asymptomatic, persons with confirmed positive HTLV-III antibody tests may transmit infection to others through anal or vaginal sexual intercourse, the sharing of needles, and possibly, exposure to others through oral-genital contact or intimate kissing.

   b. The efficacy of condoms in preventing infection with HTLV-III is unproven, but the consistent use of them may reduce transmission.

   c. Toothbrushes, razors, and other implements that may become contaminated with blood should not be shared.

   d. Persons with AIDS, ARC, or confirmed positive HTLV-III antibody tests should not donate blood, plasma, other body organs, other body tissues, or sperm. The American College Health Association also endorses the request of the American Red Cross that persons who fall into defined risk categories for AIDS not donate blood or plasma.

   e. If persons with confirmed reactive (positive) antibody tests have accidents involving bleeding, contaminated surfaces should be cleaned with household bleach freshly diluted 1:10 in water.

   f. When seeking medical, dental, or eye care, these persons should advise the practitioner of their positive antibody status so that appropriate evaluation can be undertaken and precautions can be taken to prevent transmission to others.

4. In colleges and universities with resident students, residence hall staff (both students and employees) should receive education about AIDS; in future years, the institution should provide that education prior to the arrival of new students.
5. Consideration of the existence of AIDS, ARC, or a positive HTLV-III antibody test should *not* be part of the initial admission decision for those applying to attend the institution.
6. The American College Health Association does not advocate the routine requirement that students be asked to respond to questions about the existence of AIDS, ARC, or a positive HTLV-III antibody test. It is, however, appropriate to encourage new students to inform campus health authorities if they have AIDS, ARC, or positive HTLV-III antibody test in order that the institution can provide them proper medical care and education. This, like all other medical information, must be handled in a strictly confidential manner in accordance with the procedures and requirements in effect in the institution.

7. College and university officials should not undertake programs of screening newly admitted or current students for antibody to HTLV-III; neither should mandatory screening of employees be implemented. Especially, institutions should not attempt to identify those in high risk groups and require screening only of them.

8. College and university health services should be familiar with sources of testing for antibody to HTLV-III, and should be able to refer students or employees requesting such testing. Health care providers should understand the capabilities and limitations of the test, and should be able to counsel those desiring to be tested or to refer them to counseling sources elsewhere. Testing should only be done where it is confidential or anonymous, where positive results can be confirmed by specific tests, and where both pre- and post-test counseling are available.

9. Decisions about residential housing of students with AIDS, ARC, or a positive HTLV-III antibody test must be made on a case-by-case basis. Those making such decisions should keep in mind the fact that AIDS is a condition present in an individual, not one that inhabits a building. **The best currently available medical information does not support the existence of a risk to those sharing dormitories with infected individuals; there may, however, be in some circumstances reasonable concern for the health of those with AIDS or ARC who might be exposed to certain contagious diseases (e.g., measles or chicken pox) in a close living situation.** Health officers in institutions with the flexibility to provide private rooms may wish to recommend that students with AIDS or ARC be assigned private rooms in the interest of protecting the health of those students. The American College Health Association recognizes that fear of AIDS may bring considerable pressure to bear on institutional housing officers, and will provide a more thorough discussion of options in the area of residential housing in a subsequent statement.

10. Guidelines concerning the handling of confidential medical information about students with AIDS, ARC, or a positive HTLV-III antibody test follow the general standards included in the American College Health Association's *Recommended Standards and Practices for a College Health Program*, Fourth Edition, 1984:

> In general, it is recommended that no specific or detailed information concerning complaints or diagnosis be provided to faculty, administrators, or even parents, without the expressed written permission of the patient in each case. This position with respect to health records is supported by amendment to the Family Education Rights and Privacy Act of 1974.

Certainly no person, group, agency, insuror, employer, or institution should be provided any medical information without the prior specific written consent of the patient. Given the possibility of unintended or accidental compromise of the confidentiality of information, health officers should carefully weigh the importance of including any specific information regarding the existence of AIDS, ARC, or a positive HTLV-III antibody test in the medical record except in circumstances of medical necessity created by the evaluation of an illness. At minimum, the inclusion of any such information in the medical record should be discussed with the patient prior to its entry.

Health officials and other institutional officers must remember that all confidential medical information is protected by statutes and that any unauthorized disclosure of it may create legal liability. The duty of physicians and other health care providers to protect the confidentiality of information is superseded by the necessity to protect others only in very specific, threatening circumstances. The number of people in the institution who are aware of the existence and/or identity of students or employees who have AIDS, ARC, or a positive HTLV-III antibody test should be kept to an absolute minimum, both to protect the confidentiality and privacy of the infected persons and to avoid the generation of unnecessary fear and anxiety among other students and staff. The ACHA is now developing a statement specifically addressing the handling of confidential medical information about students with AIDS, ARC, or a positive HTLV-III antibody test in more detail.

11. There is no medical necessity for institutions to advise others living in a dormitory of the presence in the dormitory of other students who have AIDS, ARC, or a positive HTLV-III antibody test. The responsibility to provide a safe living environment is best dealt with by educational programming, as discussed earlier in this statement. Similarly, college and university officials should make no attempt in any other setting to identify those students or employees who have AIDS, ARC, or a positive HTLV-III antibody test.

12. College and university health policy should encourage regular medical follow-up for those who have AIDS, ARC, or a positive HTLV-III antibody test. Special precautions to protect the health of immunologically compromised individuals should be considered during periods of prevalence of such contagious diseases as chicken pox and measles.

13. Those who are known to be immunologically compromised should be excused from institutional requirements for certain vaccinations, notably measles and rubella vaccines, as those vaccinations may lead to serious consequences in those with poorly functioning immune systems.

14. All colleges and universities should adopt safety guidelines as proposed by the Public Health Service for the handling of blood and body fluids of persons with AIDS, ARC, or a positive HTLV-III antibody test. Those institutions which operate health care clinics and clinical laboratories providing services for students or employees should implement those Public Health Service guidelines and take measures to see that they are observed. In addition, the institution should provide educational programs about AIDS and the reduction of risk to health care providers for clinical personnel. The following articles in *Morbidity and Mortality Weekly Reports* provide detailed guidelines that should be generally followed:

    A. Centers for Disease Control: Acquired Immunodeficiency Syndrome (AIDS): Precautions for Clinical and Laboratory Staffs. MMWR 1982; 31:577-580.

    B. Centers for Disease Control: Acquired Immunodeficiency Syndrome (AIDS): Precautions for Health Care Workers and Allied Professionals. MMWR 1983; 32: 450-452.

    C. Centers for Disease Control: Acquired Immunodeficiency Syndrome (AIDS): MMWR 1985; 34: 533-534.

15. College and university health services should use disposable, one-user needles and other equipment whenever such equipment will puncture the skin or mucous membranes of patients. Health care officials should not rely on students or employees to identify themselves as having AIDS, ARC, or a positive HTLV-III antibody test, since many infected persons are unaware of their status; safety precautions must be used in all cases. If disposable equipment is not available, any needles or other implements that puncture skin or mucous membranes should be steam sterilized by autoclave before reuse or safely discarded. Extreme caution should be exercised particularly in disposing of needles.

16. All colleges and universities should adopt safety guidelines for the handling of blood and body fluids of all students in other settings as well. Laboratories used in a teaching context, such as those required in biology courses, should be safe experiences. Given the fact that the existence and identity of those with AIDS, ARC, or a positive HTLV-III antibody test may not be known, procedures for the decontamination of environmental surfaces and objects soiled by blood or body fluids should be adopted and implemented. Laboratory courses requiring exposure to blood, such as finger pricks for blood typing or examination, should use disposable equipment and no lancets or other blood-letting devices should be re-used or shared. No student should be required to obtain or process the blood of others. The Public Health Service guidelines noted above include information about disinfection of environmental surfaces; a simple method they recommend is the cleaning of contaminated surfaces with a household bleach freshly diluted 1:10 in water.

17. College and university health services must strictly observe public health reporting requirements for AIDS. Patients who meet criteria for the revised surveillance definition of AIDS must be reported to the local public health authorities. The detailed surveillance definition is included in:

    Centers for Disease Control: Revision of Case Definition of AIDS for National Reporting — United States: Morbidity and Mortality Weekly Reports 1985; 34: 373-375.

The Task Force on AIDS of the American College Health Association will release in the near future a series of further statements specifically addressing:

1. Residential life issues
2. Confidentiality of information and the "need to know"
3. Educational priorities
4. Administrative issues including athletic competition, institutional employees, and public relations
5. Testing, support and counseling for those at risk
6. Clinical issues for health services

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AMERICAN COUNCIL ON EDUCATION

Division of Governmental Relations

AIDS ON CAMPUS:

Emerging Issues for College and University Administrators

Sheldon Elliot Steinbach
General Counsel
American Council on Education

(The author wishes to acknowledge the extensive direction and assistance of Eugene D. Gulland of the law firm of Covington & Burling in the preparation of this document.)

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This paper explores various questions for colleges and universities posed by AIDS, Acquired Immunodeficiency Syndrome. Any analysis of the subject is necessarily preliminary because medical understanding of this new disorder -- and the responses of courts and legislatures -- is itself in the most formative stages.

The AIDS epidemic presents a serious public health issue, despite AIDS' relatively low incidence in the general population, because there is no known medical means of prevention or treatment. The disease appears to be invariably fatal. The Center for Disease Control ("CDC") reports that currently there are more than 14,000 documented cases within the United States.

We focus here on potential issues posed by students or employees who have, or are thought to have, AIDS or AIDS-Related Complex ("ARC").[1/] Many of the same issues are posed by students or employees whose blood contains antibodies to the AIDS virus (HTLV III/LAV), because medical experts currently believe that all

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1/ ARC is characterized by a positive blood test for the HTLV III/LAV virus antibody and by such symptoms as general fatigue, swollen lymph nodes, etc. It appears that ARC sometimes (about 20 percent so far) develops into AIDS, but the frequency of this progression is unknown. Certainly any diagnosis should be made by qualified medical professionals.

All persons whose blood possesses antibodies to the HTLV III/LAV virus are thought to be at some risk of developing AIDS or ARC, but present estimates place the percentage of ultimate AIDS cases among this population in a range of 5-20 percent. Such estimates are necessarily tentative because the incubation period for AIDS may be longer for many individuals than the 3-5 years currently accepted by medical authorities and because the period of observation has thus far been short.

such persons are carriers who can transmit the virus to others even though they are otherwise free from the symptoms of AIDS or ARC. We do not address the special questions raised by university employees and students receiving or providing health care services.

Our conclusions are as lacking in finality as is knowledge of the disease. The consensus of authoritative medical opinion, as reflected by the recent recommendations of the CDC and Public Health Service ("PHS"), is that AIDS is not a readily communicable disease. It appears not to be spread through casual contact, but requires intimate sexual contact, direct exchange of body fluids, sharing of intravenous injection needles or transfusion of the blood products of an infected individual. There is no basis for concluding at this time that universities or other institutions should adopt mandatory testing of students or employees for the AIDS antibody.

We believe it is unlikely that a school, acting conscientiously on the basis of the best currently available medical information about AIDS, would be held liable simply because one student or employee transmitted the disease to another. Nonetheless, a school which learns that a student or employee has AIDS, ARC or AIDS virus antibodies may wish to take special steps, including: (1) regular monitoring of the victim's medical condition; (2) counselling the victim on the nature of the disease and against engaging in conduct that could transmit it to others; and

(3) where professional medical opinion considering the particular victim's case so indicates, insulating other members of the university community in their close contacts with the victim (e.g., sharing a room, serving food, participating in the same contact sports).

There is no basis for concluding at the present time that schools should routinely exclude or dismiss students or employees simply because they have AIDS, ARC or virus antibodies; but schools accommodating such persons should make their policy known to the university community. Schools may wish to require students having AIDS, ARC or AIDS virus antibodies to inform others (such as dormitory roommates) of the students' condition before authorizing unusually close university-sponsored contact with those persons. If a school becomes aware that a student or employee is engaging in conduct that threatens the transmission of AIDS to others in the community, it should consult promptly with medical and legal counsel about the advisability of taking action to protect against the spread of the disease.

Schools may also wish to consider public health informational programs about AIDS, which would seek to educate the academic community about the disease, its symptoms, known means of transmission and precautions for avoiding or reducing the risks of contracting it. Such programs represent a sensible response to a public health problem that can most effectively be addressed at this time by encouraging informed and responsible

individual conduct. Schools providing such programs should make sure that they remain aware of the most current available knowledge about AIDS so that the information they are disseminating is not inaccurate or incomplete.

Colleges and universities contemplating stronger steps, such as excluding (or dismissing) students or employees who may have AIDS or requiring testing, may wish to obtain legal advice. Such policies raise questions under both federal and state law (including the Federal Rehabilitation Act of 1973). Schools will generally be on firmer legal ground if they make decisions on a case-by-case basis with the support of professional medical judgment.

A. Considerations from the Standpoint of Potential Tort Liability.

Colleges and universities are obliged to exercise reasonable care in protecting "invitees" (students, faculty, administrators, etc.) on the premises from known or reasonably foreseeable danger.[1/] The school's duty is not that of an "insurer";[2/] however, a duty to protect students and other invitees from unreasonable risks of contracting AIDS could be founded on the responsibility of the college as proprietor. See Restatement

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1/ See, e.g., Korenak v. Curative Workshop Adult Rehab. Center, 237 N.W.2d 43, 36 (Wisc. 1976); Duarte v. State, 143 Cal. Rptr. 804, 808-10 (Cal. App. 1978).

2/ See, e.g., Baum v. Reed College, 401 P.2d 294 (Ore. 1965).

(2d) of Torts, §§ 314A(3) and 315 (1965). Such a duty is consistent with precedents imposing liability upon landlords, innkeepers, and employers who exposed invitees or servants to infectious diseases. See Earle v. Kuklo, 98 A.2d 107 (N.H. App. Div. 1953); Kleigel v. Aitken, 69 N.W. 67 (Wisc. 1896); Gilbert v. Hoffman, 23 N.W. 632 (Iowa 1885). Each of these decisions involved highly contagious diseases, such as tuberculosis or smallpox, which the property owners knew or should have known could be easily transmitted. Under such circumstances, the courts held that the owner had an obligation to warn those invited onto the premises.

The current, authoritative medical consensus is that AIDS is not highly contagious. The recent recommendations of the CDC and PHS are highly significant in this regard.[1/] The CDC concluded that "casual person-to-person contact as would occur among school children appears to pose no risk." CDC Report, p. 519. College officials could reasonably conclude on this basis -- particularly after confirmatory consultation with medical professionals knowledgeable about AIDS -- that routine segregation or exclusion of college-age AIDS victims or general disclosure of

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1/ See "Education and Foster Care of Children with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus," 34 Morbidity and Mortality Weekly Report, 517-21 (August 30, 1985) ("CDC Report"); "Recommendations for Preventing Transmission of Infection With Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus in the Workplace," 34 Morbidity and Mortality Weekly Report 682 (Nov. 15, 1985) ("PHS Report").

their identity to faculty and other students is unwarranted.[1/] Similarly, the PHS Report stresses that the risks of AIDS do not justify mandatory testing of employees for AIDS virus or dismissal of AIDS victims even in occupations (such as food service) involving close contact with others.[2/] That professional opinion on the question is not unanimous, or that medical knowledge is not certain, should not require precautions going far beyond what most knowledgeable experts regard as appropriate.

The CDC and PHS recommendations furnish a potential standard of reasonable care that courts should consider if a student or employee who contracts AIDS seeks to hold a college liable.[3/] The CDC and PHS guidelines provide a basis for arguing that transmission through routine personal interaction is not reasonably foreseeable and that any transmission is probably the

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1/ Indeed, in light of the CDC Report, such actions could expose colleges to litigation, as discussed infra. See New York State Ass'n. for Retarded Children v. Carey, 612 F.2d 644, 649-50 (2d Cir. 1979). In addition, the CDC guidelines note the possibility of liability for invasion of privacy being imposed if colleges were to publicize a student's carrier status. See CDC Report, p. 520.

2/ The PHS Report notes, however, that personal service workers or food service workers should not have physical contact with others or prepare or serve food if they have open lesions, "weeping dermatitis," or injuries to their hands.

3/ Extensive hearings are being conducted in cases recently brought by local school districts in New York, challenging the decision of the city's Board of Education to admit elementary school-age children suffering from AIDS. The decision in that case could set an influential precedent on the weight to be given the CDC guidelines, since the Board's decision relied heavily on the CDC Report.

result of private individual conduct for which the college should not be held responsible. See Baldwin v. Zoradi, 176 Cal. Rptr. 809 (Cal. App. 1981); Hegel v. Langsam, 273 N.E. 2d 351 (D.C. Ohio 1971).

The CDC and PHS guidelines should not be viewed as a prescription for doing nothing, however. The CDC expressly recommends that grade schools make an individualized determination regarding the appropriate educational setting for each infected student, based on consultation with medical and school personnel as well as the student's parents or guardian. The CDC also recognizes the possibility that AIDS could be spread by bites, fluids from open lesions, and direct contact with body wastes. CDC Report at 519. In each case, risks and benefits to both the AIDS victim and other students are to be weighed. Id. In addition, CDC recommends regular reevaluations. Id. at 520. CDC also suggests that sufficient numbers of school personnel be aware of an infected child's condition to ensure prompt detection of situations where the potential for transmission may increase (e.g., open sores, bleeding injury, biting behavior). Id. at 519-20.

Similarly, the PHS Report stresses that routine and continuing contact among employees and the public is not an indicated means of transmitting AIDS, even with respect to food service or personal service workers (e.g., barbers, manicurists,

etc.). PHS nevertheless recommends certain precautions that should be followed.1/

Accordingly, if a school becomes aware that a student or employee is infected with AIDS, ARC or possesses AIDS antibodies, it should consider the desirability of regularly monitoring the person's medical condition. It may wish to counsel the person about AIDS, appropriate hygiene, and the importance of not engaging in acts that are known to be likely means of transmitting the virus to others. The school may reasonably require the student or employee to submit to monitoring and counselling as a condition of continued attendance or employment. And the school should seek the guidance of medical professionals in determining what, if any, steps should be taken to separate the person from particular kinds of contact with other members of the academic community. A medical professional may conclude that some medical indications (e.g., open lesions, the victim's own vulnerability

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1/ The PHS Report points out that AIDS could be transmitted if blood or other fluids from the body of an infected personal service worker somehow enter another through a break in the skin or other "portal of entry." Page 693. The Report also recommends that personal service workers and food service workers not have "direct" contact with others, or prepare or serve food, if they have open, oozing lesions, "weeping dermatitis," or injuries to their hands. Id. Otherwise, PHS stresses that AIDS is not transmitted by casual contact and that employees with AIDS "should not be restricted from using telephones, office equipment, toilets, showers, eating facilities and water fountains." Id. at 694. PHS does recommend that any objects contaminated with the blood or other body fluids of any worker -- including those who test positive for the AIDS virus antibody -- promptly be cleaned with soap or a detergent and then disinfected. Id.

to infection) may warrant special measures for one victim, while the condition of other victims may not call for similar steps.

Schools should also consider making known their policy toward AIDS to the academic community, which would foreclose any charges that potential risks had been unreasonably "concealed." Schools considering any action that would disclose the identity of (or confidential information about) AIDS victims should only proceed with the advice of counsel, because of the strong possibility of litigation.[1/] On the other hand, a school may wish to require victims to disclose their medical condition to others with whom they are to have especially close contact (e.g., dormitory roommates) before permitting university-sponsored contact to take place. All decisions of this sort should be made with the benefit of professional medical advice.

Schools may also wish to undertake public health informational programs designed to acquaint members of the academic community with up-to-date information about the manner in which AIDS is transmitted and means of avoiding or minimizing the risks of contracting it. This represents a sensible response to what is in many respects a classic public health problem: the disease

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1/ Schools should not disclose medical information (or records) of AIDS victims without first satisfying themselves that their actions are consistent with applicable laws protecting the confidentiality of the records and the privacy of the individual. Schools should also be mindful of the potential applicability of the Buckley Amendment (20 U.S.C. § 1232g) and Education Department regulations to disclosures of student records without the student's consent (or consent of parents for students under 18 years of age).

appears to be spread chiefly by intimate contact or intravenous drug abuse; there are many unidentified, asymptomatic carriers who can transmit the disease; and informed, responsible individual conduct represents the best weapon against further spread of AIDS. So long as schools make sure that information campaigns take full account of the most current and accurate information about AIDS -- and do not raise questions under other applicable laws[1/] -- such programs should contribute both to reducing the spread of AIDS and to demonstrating schools' efforts to exercise reasonable care in protecting the academic community from the disease.

Finally, situations may arise that will force colleges and universities to make decisions requiring a particularly difficult balancing of competing rights and responsibilities. For example, a school may face the need to consider suspending, expelling or otherwise disciplining an AIDS victim who fails to heed counselling and engages in conduct known likely to infect others;

1/ Many AIDS counselling and informational programs (sponsored to date by organizations other than colleges and universities) provide information on such matters as "safe sex" practices involving methods of reducing risks or exposure short of sexual abstinence. Questions could be raised in some jurisdictions whether such counselling and informational programs promote or advocate "immoral" conduct contrary to statutes prohibiting sodomy or other sexual practices. (The question may be of particular concern if the Supreme Court upholds such statutes against constitutional challenge in the pending case of Bowers v. Hardwick, No. 85-140 (cert. granted, Nov. 4, 1985).) Schools should seek legal counsel if they intend to provide such counselling in jurisdictions where there is any reasonable likelihood of legal complications along these lines.

or it may have to decide whether to disclose to others that they have been exposed to AIDS virus through contacts with a person known to be infected. See Tarasoff v. Board of Regents, supra. In circumstances such as this, a college or university will need to decide its course of action promptly, and should do so with the benefit of professional legal and medical advice. Cases such as Bradshaw v. Rawlings, 612 F.2d 135 (3rd Cir. 1979), cert. denied, 446 U.S. 909 (1980), stand as important precedents protecting colleges from imposition of unrealistic duties to supervise their students, but there can be no assurance that all courts will adopt the same standards.1/

B. Considerations From the Standpoint of the Rehabilitation Act of 1973 And Other Laws Protecting Students.

Some colleges and universities may be considering a more actively precautionary policy against AIDS, including the exclusion of persons having the disease or virus antibodies, and perhaps even the routine testing of students and employees.

1/ Cf. Stockwell v. Board of Trustees, 148 P.2d 405 (Cal. 1944) (school's duty to police recurrent use of BB guns on campus); Eiseman v. State of New York, No. 60491 (N.Y. Ct. of Claims, decided March 21, 1983), aff'd, No. 375/85 (App. Div. 4th Dept., June 4, 1985) (murdered student was an "inexperienced adult" to whom university owed a duty of protection against meeting and consorting with dangerous companions); Tarasoff v. Regents of the University of California, supra. Cases holding that a college cannot and should not be required to police the private conduct of its students may not be regarded as establishing the limits of a college's duties where it has notice that an infected student may be failing to exercise due care in contacts with others.

These actions go well beyond the precautions recommended by the CDC and PHS Reports. The first order of business for any school weighing such action is to assess whether there is any applicable state law or judicial decisions.[1/]

Schools will also need to consider the potential applicability of Sections 503-504 of the Rehabilitation Act of 1973, 29 U.S.C. §§ 793-794, which prohibit discrimination against "qualified handicapped individual[s]" in programs or activities conducted with federal financial assistance.[2/] This issue is presented by at least one of the growing number of AIDS cases in litigation.[3/] The strong weight of authority holds that individuals alleging unreasonable discrimination under the law have a private right of action. See Kling v. County of Los Angeles, 633

1/ California, for example, has enacted legislation forbidding discrimination in such matters as employment and insurance coverage on the basis of a positive blood test for the AIDS virus antibody. See Cal. Health and Safety Code § 199.21(f). This law reflects in part a response to the fact that there are many "false positive" responses to the commonly used ELISA blood test, and the desire not to discourage persons from having their blood tested.

2/ Section 503 prohibits employment discrimination against "qualified handicapped individuals" in activities conducted under federal contracts; Section 504 forbids discrimination against "qualified handicapped individuals" in connection with any "program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive Agency or by the United States Postal Service." Judicial decisions hold that Section 504 also reaches employment discrimination.

3/ This is the widely-publicized case in which a public secondary school in Kokomo, Indiana, excluded a 13-year-old hemophiliac AIDS victim from attending school. Ryan White v. Western School Corp., No. 85-1192-C (S.D. Ind.).

F.2d 879 (9th Cir. 1980); Jones v. Metropolitan Atlanta Rapid Transit Authority, 681 F.2d 1376, 1377 n.1 (11th Cir. 1982), cert. denied, 104 S.Ct. 1591 (1984).

A detailed analysis of Sections 503-504 is beyond the scope of this memorandum. The important point for our purposes is that both the statute (Section 7(7), 29 U.S.C. § 706(7)) and implementing regulations (see 45 C.F.R. § 84(j)(2)) define "handicap" and "handicapped individual" most broadly. In a very recent case, the Eleventh Circuit -- reversing the district court -- held that protected "handicapped individual[s]" include those suffering from chronic contagious diseases such as tuberculosis. Arline v. School Board of Nassau County, No. 84-3307 (decided Sept. 30, 1985).

Arline follows the Second Circuit's decision in New York State Ass'n for Retarded Children v. Carey, 612 F.2d 644, 650 (1979), which is especially relevant to issues presented by AIDS. In Carey, school officials isolated retarded children who were carriers of Hepatitis B virus, which appears to be quite similar to the AIDS virus in the manner of its transmission.[1/] The court held that the children's isolation violated Section 504 of the Rehabilitation Act because school officials were "unable to demonstrate that the health hazard posed by the hepatitis B

1/ The PHS Report describes the similarities between the means of transmission of the Hepatitis B and AIDS viruses, but concludes that the risk of transmitting Hepatitis B significantly exceeds that of AIDS. Page 683.

carrier children was anything more than a remote possibility." 612 F.2d at 650.

This does not mean that schools are invariably forbidden from treating AIDS or ARC victims differently from other students or employees having no communicable disease or other "handicap." The regulations implementing the statute restrict its reach to "situations where the handicapped individual would be 'otherwise qualified' if given 'reasonable accommodation.'" Arline v. School Board, supra, citing 45 C.F.R. §§ 84.3(k)(1) and -84.12, and Southeastern Community College v. Davis, 442 U.S. 397, 410-13 (1979). The court in Arline explained that, in the circumstances of potentially contagious tuberculosis, the school was required at a minimum to make a "well-informed judgment grounded in a careful and open-minded weighing of the risks and alternatives" and could not rely on "reflexive reactions grounded in ignorance or capitulation to public prejudice." Id., citing Strathie v. Department of Transportation, 716 F.2d 227 (3d Cir. 1983); New York State Ass'n of Retarded Children v. Carey, supra.

These cases, in essence, point to the same virtues of conscientious decisions based upon professional medical judgments about an individual AIDS victim's specific circumstances that are suggested in Section A of this memorandum. Arline, Carey and the Department of Health and Human Resources' regulations suggest also that a school should weigh the possible steps, short of dismissal or exclusion of AIDS victims, that would reasonably

balance their individual interests against concern for the welfare of the academic community.1/

This is not to say that courts will require colleges and universities to uniformly and invariably make such "accommodation" to students having AIDS, ARC or AIDS virus antibodies. Conscientious weighing of the benefits and risks in particular circumstances may, in the view of courts, warrant exclusion or dismissal of students because of the uncertainties surrounding AIDS and the seriousness of the disease. Some reputable medical experts have called for a more vigorous public health response to AIDS than government has mustered so far, including mandatory testing before issuance of marriage licenses and strict controls on the conduct of AIDS victims who continue to be sexually

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1/ DHHS regulations for handicapped students suggest "reasonable accommodations" such as extending the time permitted for completion of degree requirements; devising methods of examination that measure a student's achievement while minimizing the degree to which the handicaps hinder performance on traditional examinations; providing auxiliary aids such as taped texts and interpreters; and offering accessible housing at the same cost as shelter available to other students. 45 C.F.R. § 84.31. Schools that accept and follow the CDC and PHS recommendations would rarely find it necessary to provide "accommodations" in the form of isolating students or employes from contact with others.

The concept of accommodation is not, however, limitless. Institutions are not required to engage in substantial modifications which they reasonably conclude would cause undue hardship or which would inherently compromise the essential educational requirements of a particular program. See Southeastern Community College v. Davis, 442 U.S. 397 (1978); note, Accommodating the Handicapped: Rehabilitating Section 504 after Southeastern, 80 Colum. L. Rev. 171 (1980).

UNIVERSITY OF MASSACHUSETTS

Executive Staff Action Item Form

Analysis of University Policy on AIDS

I. Statement of Problem
The national and local scope of concern regarding persons with AIDS requires a clear University policy covering both students and employees of the University who contract the Acquired Immune Deficiency Syndrome or AIDS related disorders.

II. Background of Problem
With recent national publicity on AIDS, many students, parents, and employees have expressed concerns about their health and safety. Since AIDS is still an extremely fatal disease, a clear policy that gives accurate information is necessary.

III. Recommendation for Resolution
See attached policy which gives procedures that will be followed with students and employees with AIDS or AIDS associated illnesses, as well as background information. In general, each case will be handled based on its medical situation. Dr. McBride, Medical Director of the University Health Services, will have final say regarding conflicts which may arise in individual cases.

IV. Other Alternatives Considered
None. The recommended policy is consistent with policies and guidelines issued by the Department of Public Health in the Commonwealth of Massachusetts and the Center for Disease Control.

V. Follow-up Action Required/To Be Done by Whom:
A number of campus agencies/offices must have clear procedures and guidelines which support and administer the recommended policy. Most of the work to prepare these should begin as soon as possible. A partial list of affected areas on campus and steps needed is attached. Health Services, Student Affairs and other executive areas will need to monitor campus situations and work with relevant parties as necessary.

Prepared by: Dennis L. Madson Date: November 15, 1985

Reviewed by VCs

Disposition of Action:

___Forwarded to Executive Staff for Action on _____
Date

___Forwarded to Chancellor for Information on _____
Date

___Forwarded to Chancellor for Signature on _____
Date

Returned to VC for Rework _____
Date

_____Rejected _____

POLICY FOR SCHOOL AND WORK ATTENDANCE BY UNIVERSITY STUDENTS OR EMPLOYEES WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Policy

AIDS is caused by a fragile virus and is not transmissible by casual contact. Individuals diagnosed as having AIDS or with clinical evidence of infection with the AIDS associated virus (HTLV-III) and receiving regular medical attention are allowed to attend work or school at the University of Massachusetts at Amherst. As with any personal medical problem, every effort should be made to protect the individual's privacy and confidentiality with this diagnosis.

Background

The following guidelines govern attendance at the University of Massachusetts by students or attendance at work by employees of the University who have Acquired Immune Deficiency Syndrome (AIDS) or with clinical evidence of infection with the AIDS associated virus (HTLV-III). Our policy is similar to the policy developed in the Commonwealth's schools by the Governor's Task Force on AIDS. It has been based on recommendations of the Department of Public Health and endorsement of the Department of Education and is consistent with the Center for Disease Control's Guidelines published August 30, 1985. The policy draws heavily on the current knowledge of infectious disease epidemiology and on well established principles of disease prevention and control.

Epidemiologic studies show that AIDS is transmitted by sexual contact or by blood to blood contact, including transmission by an infected pregnant woman to her unborn child. To date, there has been no recorded transmission of AIDS to family members who are non-sexual contacts, nor has there been any transmission to medical personnel who directly care for AIDS patients, except for accidental blood to blood transmission. Shared classrooms, study areas, libraries, theaters, common bathrooms, sports facilities, etc., do not represent problems. Decisions on residence hall assignments for AIDS patients should be made on an individual basis.

Guidelines

Since there is no evidence of casual transmission by sitting near, living in the same household, or attending class with AIDS patients, the following guidelines will be followed:

1. All students diagnosed as having AIDS or with clincial evidence of infection with the AIDS associated virus (HTLV-III) and receiving medical attention will be allowed to attend regular classes and participate in all phases of University life. Similarly, all staff diagnosed as having AIDS or AIDS-related disorders and receiving medical attention will be allowed to carry out their normal work functions. Exceptions to this would be an individual who has skin eruptions or weeping lesions that cannot be covered, and therefore is at risk of getting an infection; individuals with inappropriate behavior (e.g., intravenous drug abuse) which increases the likelihood of transmission; or individuals who are too ill to attend the University or to assume their ususal working responsibilities.

2. All individuals at the University diagnosed as having AIDS or AIDS-related disorders are strongly urged to be monitored by one of the medical staff at the University Health Services (UHS), even if he/she is receiving clinical care from an off-campus physician. The on-campus monitor is chiefly to protect the privacy of the individual, so that medically sensitive information does not get into personnel, academic or administrative records, and to assist with any special needs of the individual on-campus. Any University student or employee learning of a person who may have AIDS or AIDS-related disorders should encourage the individual to contact the UHS Public Health Nurse (549-2671, ext. 136) for follow-up.

    a. For students, the student's personal physician at the University Health Services, or the UHS Medical Director, would be the primary on-campus manager of the student with AIDS or clinical evidence of infection with the AIDS associated virus. If a student chooses to receive primary clinical care from an off-campus physician, then the off-campus physician would make recommendations to the Medical Director regarding special needs of the patient.

    b. For employees, the Occupational Health Physician would be the primary on-campus manager of the employee with AIDS or with clinical evidence of infection with AIDS associated virus. The employee's personal physician would function as the primary clinical manager and would make recommendations to the Occupational Health Physician or the UHS Medical Director for the patient's attendance at work.

    c. The personal physician after consultation with the patient is responsible for reporting cases of AIDS to the Massachusetts Department of Public Health's Division of Communicable Diseases. Other individuals will not be informed of this diagnosis except in very unusual circumstances and only with permission of the patient.

3. Since individuals having AIDS or with clinical evidence of infection from AIDS associated virus (HTLV-III) have a somewhat greater risk of encountering infections in an institutional setting such as the University, the individual may be excluded if there is an outbreak of a communciable disease (such as chicken pox or measles) until he/she is properly treated and/or the outbreak is no longer a threat to the individual.

4. HTLV-III screening is a blood test for detecting the presence of antibody to the HTLV-III virus. (Antibodies are substances produced by the white cells that help fight infections caused by viruses or bacteria.) Testing for HTLV-III antibody is not recommended for any purposes other than to screen potential blood donors and to assist the personal physician of an individual in a highly selected set of clinical decisions. Results of HTLV-III antibody tests are confidential and will not be reported to the University or any off-campus agencies.

5. The University Health Services provides a full range of services for students, including health care, counseling, consultation and health education services for patients with AIDS, friends/acquaintances of AIDS victims, or interested groups. The Occupational Health Program, including the Employee Assistance Program, provides evaluation and referral services for employees with AIDS or AIDS-related disorders, as well as consultation and education services regarding questions about AIDS.

Questions concerning either this policy or specific case exposure should be referred to the Executive Director or Medical Director, University Health Services, for clarification.

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UNIVERSITY POLICY ON AIDS

ATTACHMENT

The following are areas which need to be addressed to assure effective and equitable implementation of the campus AIDS policy. Dr. McBride should be made aware of any procedures written and whom to contact in Personnel, Academic Affairs, and all Student Affairs divisions. This list is not exhaustive; persons with additional concerns should contact either Dr. McBride or Sarah Boy.

Personnel

Must be prepared to deal with questions about the University as a workplace. The following issues have already been raised in various settings:

- requests for transfer to avoid AIDS co-worker
- refusal to work next to AIDS victim
- refusal to perform specific tasks, e.g., cleaning toilets, silverware, laboratories, and disposal of needles
- sick leave policies
- disability
- "reasonable accommodation" of AIDS victims
- merit
- union concerns and support
- who to arbitrate (in conjunction with Dr. McBride)

Dean of Students

General: Must have complete and current information on all relevant policies and procedures to respond to inquiries, especially those of parents and students.

Child Care: May need to implement different policy for children under 4 as well as respond to concerns of child care parents and staff.

Academic Affairs

Must know how and by whom decisions will be made in cases such as:

- requests for change of section
- grade disputes
- refusal to work with lab partner/in group project

Is there a procedure for lab safety, disposal of needles, any bloody supply?

If student is removed from class for own safety during chicken pox epidemic (cf. policy), how is missed work treated?

Housing

Any written policy should be accessible and clear.

If someone is removed for own safety during chicken pox epidemic (cf. policy), does student get refund for housing?

Blood Drive

Is there a campus coordinator? Should there be?

University Health Services

Bears overall responsibility for campus decisions and will work with other campus agencies as necessary.

Will clarify role in confidential testing for HTLV III antibody testing.

Campus AIDS Education

Is being coordinated by University Health Services, with help from Program for Gay, Lesbian and Bisexual Concerns, and Housing staff.

A videotape is being prepared for presentation in Campus Center and residence halls.

A pamphlet on "safe sex" and one on the particular dangers of intravenous drug use are being prepared.

Athletics

Should review policy to see whether any additional guidelines/ procedures are needed.

Public Safety

Must be prepared to deal with:

- refusal to provide service (breaking up fights, etc.)
- emergency responses which call for CPR or mouth to mouth resuscitation
- refusal to work with colleagues

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APPENDIX A

August 1, 1985

The Case Definition of AIDS
Used by CDC for National Reporting
(CDC-reportable AIDS)

For the limited purposes of national reporting of some of the severe late manifestations of infection with human T-lymphotropic virus, type-III/lymphadenopathy-associated virus (HTLV-III/LAV) in the United States, CDC defines a case of "acquired immunodeficiency syndrome" (AIDS) as an illness characterized by:

I. one or more of the opportunistic diseases listed below (diagnosed by methods considered reliable) that are at least moderately indicative of underlying cellular immunodeficiency, and

II. absence of all known underlying causes of cellular immunodeficiency (other than HTLV-III/LAV infection) and absence of all other causes of reduced resistance reported to be associated with at least one of those opportunistic diseases.

Despite having the above, patients are excluded as AIDS cases if they have negative result(s) on testing for serum antibody to HTLV-III/LAV*, do not have a positive culture for HTLV-III/LAV, and have both a normal or high number of T-helper (OKT4 or LEU3) lymphocytes and a normal or high ratio of T-helper to T-suppressor (OKT8 or LEU2) lymphocytes. In the absence of test results, patients satifying all other criteria in this definition are included as cases.

This general case definition may be made more explicit by specifying:

I. the particular diseases considered at least moderately indicative of cellular immunodeficiency, which are used as indicators of AIDS, and

II. the known causes of cellular immunodeficiency, or other causes of reduced resistance reported to be associated with particular diseases, which would disqualify a patient as an AIDS case.

This specification is as follows:

I. <u>Diseases at least moderately indicative of underlying cellular immunodeficiency:</u>

In the following list of diseases, the required diagnostic methods with positive results are shown in parentheses. "Microscopy" may include cytology.

* A single negative test for HTLV-III/LAV may be applied here if it is an antibody test by ELISA, immunofluorescent, or Western Blot methods, because such tests are very sensitive. Viral cultures are less sensitive but more specific, and so may be relied on if positive but not if negative. If multiple antibody tests have inconsistent results, the result applied to the case definition should be that of the majority. A positive culture, however, would over-rule negative antibody tests.

A. Protozoal and Helminthic Infections:

1. Cryptosporidiosis, intestinal, causing diarrhea for over 1 month, (on histology or stool microscopy)

2. Pneumocystis carinii pneumonia, (on histology, or microscopy of a "touch" preparation, bronchial washings, or sputum)

3. Strongyloidosis, causing pneumonia, central nervous system infection, or infection disseminated beyond the gastrointestinal tract, (on histology)

4. Toxoplasmosis, causing infection in internal organs other than liver, spleen, or lymph nodes (on histology or microscopy of a "touch" preparation)

B. Fungal Infections:

1. Candidiasis, causing esophagitis (on histology, or microscopy of a "wet" preparation from the esophagus, or endoscopic or autopsy findings of white plaques on an erythematous mucosal base, but not by culture alone)

2. Cryptococcosis, causing central nervous system or other infection disseminated beyond lungs and lymph nodes (on culture, antigen detection, histology, or India ink preparation of CSF)

C. Bacterial Infections:

1. Mycobacterium avium or intracellulare (Mycobacterium avium complex), or Mycobacterium kansasii, causing infection disseminated beyond lungs and lymph nodes (on culture)

D. Viral Infections:

1. Cytomegalovirus, causing infection in internal organs other than liver, spleen, or lymph nodes (on histology or cytology, but not by culture or serum antibody titer)

2. Herpes simplex virus, causing chronic mucocutaneous infection with ulcers persisting more than 1 month, or pulmonary, gastrointestinal tract (beyond mouth, throat, or rectum), or disseminated infection (but not encephalitis alone)(on culture, histology, or cytology)

3. Progressive multifocal leukoencephalopathy (presumed to be caused by Papovavirus)(on histology)

E. Cancer:

1. Kaposi's sarcoma (on histology)

2. Lymphoma limited to the brain (on histology)

F. Other Opportunistic Infections with Positive test for HTLV-III/LAV*:

In the absence of the above opportunistic diseases, any of the following diseases is considered indicative of AIDS if the patient had a positive test for HTLV-III/LAV*:

1. disseminated histoplasmosis, (on culture, histology, or cytology)

2. bronchial or pulmonary candidiasis, (on microscopy or visualization grossly of characteristic white plaques on the bronchial mucosa, but not by culture alone)

3. isosporiasis, causing chronic diarrhea (over 1 month), (on histology or stool microscopy)

G. Chronic lymphoid interstitial pneumonitis:

In the absence of the above opportunistic diseases, a histologically confirmed diagnosis of chronic (persisting over 2 months) lymphoid interstitial pneumonitis in a child (under 13 years of age) is indicative of AIDS unless test(s) for HTLV-III/LAV are negative.* The histologic examination of lung tissue must show diffuse interstitial and peribronchiolar infiltration by lymphocytes, plasma cells with Russell bodies, plasmacytoid lymphocytes and immunoblasts. Histologic and culture evaluation must not identify a pathogenic organism as the cause of this pneumonia.

H. Non-Hodgkin's Lymphoma with Positive Test for HTLV-III/LAV*:

If the patient had a positive test for HTLV-III/LAV*, then the following histologic types of lymphoma are indicative of AIDS, regardless of anatomic site:

1. Small noncleaved lymphoma (Burkitt's tumor or Burkitt-like lymphoma), but not small cleaved lymphoma,

2. Immunoblastic sarcoma (or immunoblastic lymphoma) of B-cell or unknown immunologic phenotype (not of T-cell type). Other terms which may be equivalent include: diffuse undifferentiated non-Hodgkin's lymphoma, large cell lymphoma (cleaved or noncleaved), diffuse histiocytic lymphoma, reticulum cell sarcoma, and high-grade lymphoma.

Lymphomas should not be accepted as indicative of AIDS if they are described in any of the following ways: low grade, of T-cell type (immunologic phenotype), small cleaved lymphoma, lymphocyte lymphoma (regardless of whether well or poorly differentiated), lymphoblastic lymphoma, plasmacytoid lymphocytic lymphoma, lymphocytic leukemia (acute or chronic), or Hodgkin's disease (or Hodgkin's lymphoma).

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* a positive test for HTLV-III/LAV may consist of a reactive test for antibody to HTLV-III/LAV or a positive culture (isolation of HTLV-III/LAV from a culture of the patient's peripheral blood lymphocytes). If multiple antibody tests have inconsistent results, the result applied to the case definition, should be that of the majority done by the ELISA, immunofluorescent, or Western Blot methods. A positive culture, however, would over-rule negative antibody tests.

II. Known Causes of Reduced Resistance:

Known causes of reduced resistance to diseases indicative of immunodeficiency are listed in the left column, while the diseases that may be attributable to these causes (rather than to the immunodeficiency caused by HTLV-III/LAV infection) are listed on the right:

Known Causes of Reduced Resistance	Diseases Possibly Attributable to the Known Causes of Reduced Resistance
1. Systemic corticosteroid therapy	Any infection diagnosed during or within 1 month after discontinuation of the corticosteroid therapy, unless symptoms specific for an infected anatomic site (e.g., dyspnea for pneumonia, headache for encephalitis, diarrhea for colitis) began before the corticosteroid therapy or any cancer diagnosed during or within 1 month after discontinuation of more than 4 months of long-term corticosteroid therapy, unless symptoms specific for the anatomic sites of the cancer (as described above) began before the long-term corticosteroid therapy
2. Other immunosuppressive or cytotoxic therapy	Any infection diagnosed during or within 1 year after discontinuation of the immunosuppressive therapy, unless symptoms specific for an infected anatomic site (as described above) began before the therapy or any cancer diagnosed during or within 1 year after discontinuation of more than 4 months of long-term immunosuppressive therapy, unless symptoms specific for the anatomic sites of the cancer (as described above) began before the long-term therapy
3. Cancer of lymphoreticular or histiocytic tissue such as lymphoma (except for lymphoma localized to the brain), Hodgkin's disease, lymphocytic leukemia, or multiple myeloma	Any infection or cancer, if diagnosed after or within 3 months before the diagnosis of the cancer of lymphoreticular or histiocytic tissue

Known Causes of Reduced Resistance	Diseases Possibly Attributable to the Known Causes of Reduced Resistance
4. Age 60 years or older at diagnosis	Kaposi's sarcoma, but not if the patient has a positive test for HTLV-III/LAV
5. Age under 28 days (neonatal) at diagnosis	Toxoplasmosis or herpes simplex virus infection, as described above
6. Age under 6 months at diagnosis	Cytomegalovirus infection, as described above
7. An immunodeficiency atypical of AIDS, such as one involving hypogammaglobulinemia or angio-immunoblastic lymphadenopathy; or an immunodeficiency of which the cause appears to be a genetic or developmental defect, rather than HTLV-III/LAV infection	Any infection or cancer diagnosed during such immunodeficiency
8. Exogenous malnutrition (starvation due to food deprivation, not malnutrition due to malabsorption or illness)	Any infection or cancer diagnosed during or within 1 month after discontinuation of starvation

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no treatment has been successful in restoring normal immune system functioning. Effective treatment for AIDS may require a combination antiviral agents and substances that enhance immune responsiveness (see Appendix M).

Some of the opportunistic infections that affect AIDS patients often respond to antimicrobial therapy, although they are likely to relapse. These include P. carinii pneumonia, T. gondi, candida species, C. neoformans, herpes simplex, and herpes zoster. For other opportunistic infections there is no effective antibiotic therapy currently available. Examples are M. avium-intracellulare and Epstein-Barr virus. Finally, some infections are unresponsive to conventional therapy, but may prove responsive to experimental drugs currently being tested. Included in this group are cytomegalovirus and cryptosporidia.

The ultimate success in controlling [illegible] AIDS most likely depends on developing [illegible] dysfunction.[12]

12. [illegible]
Comment [illegible]

[illegible] who is in a category at increased risk for developing AIDS.

Clinical

1. Fever: ≥100 F, intermittent or continuous, for at least 3 months, in the absence of other identifiable causes.

2. Weight Loss: ≥ 10% or ≥ 15 lbs.

3. Lymphadenopathy: persistent for at least 3 months, involving

≥ 2 extra-inguinal node bearing areas.

4. Diarrhea: intermittent or continuous, ≥ 3 months, in the absence of other identifiable causes.

5. Fatigue, to the point of decreased physical or mental function.

6. Night Sweats: intermittent or continuous, ≥ 3 months, in the absence of other identifiable causes.

Laboratory

1. Depressed helper T-cells. (≥2 standard deviations below mean).

2. Depressed helper/suppressor ratio. (≥2 standard deviations below mean).

3. At least one of the following: leukopenia, thrombocytopenia, absolute lymphopenia or anemia.

4. Elevated serum globulins.

5. Depressed blastogenesis (pokeweed and PHA).

6. Abnormal skin tests (using Multi-Test or equivalent).

In addition to the conditions just described, idiopathic thrombocytopenia is probably associated with HTLV-III infection, as are a variety of non-life-threatening fungal, viral, and bacterial infectious processes which probably represent manifestations of HTLV-III-induced immunologic perturbation. These manifestations are sometimes termed "lesser AIDS", although for a person to actually be diagnosed as having AIDS they must meet the criteria given in Appendix A.

The chronic lymphadenopathy syndrome and ARC appear to be part of the clinical spectrum of infection with HTLV-III. It is estimated that the risk of ARC in a person with HTLV-III infection may be 20-40% within the first 3-5 years of infection. In some patients, the chronic lymphadenopathy syndrome and ARC may represent a prodome of AIDS, whereas in others they may represent an end point of the infection. Not all individuals with chronic lymphadenopathy syndrome or ARC have progressed to frank AIDS, and not all patients with full-blown AIDS have passed through an identifiable prodromal stage. Currently there is no specific test to predict which patients with chronic lymphadenopathy syndrome or ARC are likely to develop AIDS. (The chronic lymphadenopathy syndrome is also referred to as the lymphadenopathy syndrome, or pre-AIDS. However, since not all persons with these symptoms who will progress to frank AIDS, the use of terms such as pre-AIDS should be avoided.)■

13. WHAT IS THE NATURAL HISTORY OF INFECTION WITH HTLV-III?

COMMUNICABLE DISEASE REGULATION HCD–33
STATE OF INDIANA

A REGULATION, pursuant to the authority found in IC 16-1-3-13, setting forth requirements for the detection, reporting, prevention, and control of communicable diseases which affect public health and amending in its entirety Regulations HCD 1 through HCD 29, promulgated March 25, 1958, and Regulations HVD 1 through HVD 8, promulgated March 20, 1952.

SECTION 1—DEFINITIONS—As used in this Regulation, unless otherwise provided:

1.1 **Carrier**—A person who, without apparent symptoms of a communicable disease, harbors the specific infectious agent and may serve as a source of infection. The same may apply to animal carriers. The carrier state may occur in the incubation period or during convalescence, or may become chronic and of indefinite duration.

1.2 **Communicable disease**—An illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a well person from an infected person, animal, or arthropod, or through the agency of an intermediate host, vector, or the inanimate environment.

1.3 **Communicable period**—The time or times during which the etiologic agent may be transferred directly or indirectly from an infected person, to another person, or from an infected animal to man.

1.4 **Contact**—Any person or animal known to have been in such association with an infected person or animal as to have been presumably exposed to infection.

1.5 **Contamination**—The presence of a disease producing agent on a body surface or on or in an inanimate article or substance.

1.6 **Immune person**—An immune person is one who possesses specific protective antibodies or cellular immunity as a result of previous infection or immunization, or is so conditioned by such previous specific experience as to respond adequately with production of antibodies sufficient in either instance to protect from illness following exposure to the etiologic agent of the disease. Immunity is relative; an ordinarily effective protection may be overwhelmed by an excessive dose of the infectious agent or an unusual portal of entry.

1.7 **Isolation**—"Isolation," except as specifically modified elsewhere in this regulation, shall consist of: Either the care of the patient in a hospital approved by the local health officer, or the continuous separation of the patient or patients in a room used for no purpose other than their care. Isolation therefore requires the exclusion of all persons except the physician, the nurse, the minister and spiritual practitioner, or the attendant, and such others as may be admitted by order of the health officer.

1.8 **Placarding**—The posting of a prescribed warning notice upon the street side of door or entrance to living quarters of persons isolated because of communicable disease. (see Section 5.3)

1.9 **Surveillance**—The practice of close supervision of contacts without restricting their movements.

1.10 **Suspect**—A person whose medical history and/or symptoms suggest that he may have or be developing some communicable disease.

1.11 **Quarantine**—The restriction of movement of well persons or animals who have been exposed to a communicable disease. The restriction shall be for the complete incubation period.

SECTION 2—DISEASE REPORTING

2.1 **Diseases Reportable by Name**

(a) It shall be the duty of all superintendents, responsible officers or duly appointed representatives of each hospital in this state and all physicians to report within 24 hours all cases and suspected cases of the diseases listed below in this regulation to the local health officer in whose jurisdiction the patient is at the time of diagnosis. Such reports shall include the full name, address, age, sex, race, date of onset, diagnosis, and the name and address of the attending

physician. Cases reported by identifying data to the local health officer and/or the Indiana State Board of Health shall be confidential and shall not be disclosed except by: (1) court order; or (2) upon receipt of a written, signed and notarized request of the patient, parent, or legal guardian to substantiate insurance claims. Information from such reports will be utilized for epidemiological investigation as warranted and without identification for statistical purposes. Such report shall be made on the official report card prescribed and furnished by the State Board of Health, or by telephone or other oral means of communication. Those diseases marked by asterisk (*) shall be reported immediately (as soon as the diagnosis is suspected) by telephone.

Amebiasis (see Section 4.1)
Animal Bites (see Section 4.13)
*Anthrax
*Botulism
Brucellosis
*Cholera
*Diphtheria (see Section 4.4)
*Diarrhea of Newborn (occurring in hospitals or other institutions)
Encephalitis, Acute Infectious (see Section 4.5)
*Food Poisoning (see Section 2.4)
Hepatitis, Viral, Type A (Infectious) (see Section 4.7-a)
Hepatitis, Viral, Type B (Serum) (see Section 4.7-b)
Leptospirosis
Leprosy (Hansen's Disease) (IC 16-1-13)
Malaria
Measles (Rubeola) (see Section 4.8)
Meningitis, Aseptic (see Section 4.9-c)
Meningitis, Meningococcal, and Other Meningococcal Disease (see Section 4.9-a)
Meningitis, Other Bacterial (see Section 4.9-b)
Mumps (see Section 4.10)
Ophthalmia Neonatorum, Gonococcal (see Section 4.6)
Pertussis (see Section 4.11)
*Poliomyelitis (see Section 4.12)
Psittacosis
*Rabies (see Section 4.13)
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Congenital Syndrome
Salmonellosis, other than Typhoid Fever (see Section 4.14)
Shigellosis (see Section 4.15)
*Smallpox
Tetanus
Trichinosis
Tularemia
Typhoid Fever (see Section 4.17)
Typhus—Endemic (flea-borne)
*Typhus—Epidemic (louse-borne)
*Yellow Fever

(b) Other communicable diseases which are not prevalent in Indiana but are dangerous to the public health when they do occur and are not mentioned elsewhere in this regulation and any extraordinary outbreak of illness **shall be reported in a like manner.**

(c) Venereal diseases shall be reported in accordance with Section 2.2 of this Regulation.

(d) Tuberculosis shall be reported in accordance wth IC 16-1-10-1 and Regulations HT 1 R through HT 13 promulgated March 14, 1972, or any amendment thereof.

(e) Certain of the above diseases are also covered by specific sections of this Regulation.

2.2 **Venereal Disease Reporting**—It shall be the duty of the attending physician immediately upon discovering a case or suspected case of syphilis, gonorrhea, granuloma inguinale, lymphogranuloma venereum, or chancroid to report such case directly, by mail, to the Division of Communicable Disease Control, Indiana State Board of Health, Indianapolis, Indiana, 46206. Such reports will be made on confidential venereal disease morbidity report forms provided by the Indiana State Board of Health, and will include all the identifying information requested on the forms. These reports shall be confidential and will not be disclosed except on court order but may be utilized for epidemiological investigation as warranted and for statistical purposes without identification.

2.3 **Reports Without Identifying Data (By Number Only)**—It shall be the duty of all physicians to report within 24 hours from the time of diagnosis all diseases or infestations listed below in this section to the local health officer. All cases shall be excluded from schools or public gatherings as specified by the local health officer. The report may be made by number of cases of each

CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

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Current Trends

Recommendations for Assisting in the Prevention of Perinatal Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus and Acquired Immunodeficiency Syndrome

The information and recommendations in this document are intended to assist health-care providers and state and local health departments in developing procedures to prevent perinatal transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes acquired immunodeficiency syndrome (AIDS).

This document contains recommendations for providing counselling and, when indicated, testing for antibody to HTLV-III/LAV for women who are at increased risk of acquiring the virus and who are either pregnant or may become pregnant. It is important that these women know they are at risk, as well as know and understand their HTLV-III/LAV-antibody status, so they can make informed decisions to help prevent perinatally acquired HTLV-III/LAV.

Through counselling, uninfected women can learn how to avoid becoming infected, and infected women can choose to delay pregnancy until more is known about perinatal transmission of the virus. If already pregnant, infected women can be provided information for managing the pregnancy and caring for the child.

Currently available data indicate that most pediatric HTLV-III/LAV infections and AIDS are acquired perinatally from infected women, but additional studies are needed to better quantify the risk of transmission from an infected pregnant woman to the fetus or newborn.

The recommendations below pertain to women. However, men who are HTLV-III/LAV-antibody positive should also be counselled regarding the risks of sexual and perinatal transmission, so they can refer for counselling and testing their sex partners who may be pregnant or considering pregnancy.

BACKGROUND

Pediatric AIDS Cases due to Perinatal Transmission. As of December 1, 1985, 217 (1%) of the 15,172 AIDS cases reported to CDC occurred among children under 13 years of age. Sixty percent of these children are known to have died. These 217 cases represent only the more severe manifestations of HTLV-III/LAV infection. Less severe manifestations, often described as AIDS-related complex (ARC), are not reported to CDC, so the number of children with clinically significant illness attributable to HTLV-III/LAV infection is greater than the reported cases of pediatric AIDS. In addition, a number of infected children are probably asymptomatic.

HTLV-III/LAV – Continued

Of the 217 reported pediatric AIDS patients, 165 (76%) have as their only known risk factor a mother belonging to a group with increased prevalence of HTLV-III/LAV infection. An additional 18% of the pediatric cases are attributable to transfusions of blood or blood products, while risk factor information is missing or incomplete on the remaining 6%. Of the 217 children with AIDS, 48% had mothers who were intravenous (IV) drug abusers; 17% had mothers who were born in Haiti; and 10% had mothers who were sex partners of either IV drug abusers or bisexual men.

Of the patients with perinatally acquired AIDS, 45% resided in New York City, while Florida and New Jersey accounted for an additional 32%.

Mechanisms of Perinatal Transmission. It is believed that HTLV-III/LAV is transmitted from infected women to their fetuses or offspring during pregnancy, during labor and delivery, or perhaps shortly after birth. Transmission of the virus during pregnancy or labor and delivery is demonstrated by two reported AIDS cases occurring in children who had no contact with their infected mothers after birth. One was delivered by Cesarean section (*1,2*).

Transmission of the virus after birth has been implicated in one case of HTLV-III/LAV infection in a child born to a mother reported to have acquired the infection from a postpartum blood transfusion. Since she breastfed the child for 6 weeks, the authors suggested breastfeeding as the possible mode of transmission (*3*). Recently, HTLV-III/LAV has been isolated from the breast milk of infected women (*4*).

Risk of Perinatal Transmission from Infected Mothers. The rate of perinatal transmission of HTLV-III/LAV from infected pregnant women is unknown; however, available data suggest a high rate. In one study of 20 infants born to infected mothers who had already delivered one infant with AIDS, 13 (65%) had serologic and/or clinical evidence of infection with HTLV-III/LAV several months after birth (*5,6*). Since these women were selected on the basis of having previously transmitted HTLV-III/LAV perinatally, this study may overestimate the average risk of transmission for all infected pregnant women.

Perinatal transmission from an infected mother to her newborn is not inevitable. Of three children born to women who became infected with HTLV-III/LAV by artificial insemination from an infected donor, all were in good health and negative for antibody to the virus more than 1 year after birth (*7*). Another child, born to a woman who was already pregnant at the time of AIDS diagnosis and was demonstrated to be viremic, was seronegative, culture negative, and healthy at birth and at 4 months of age (*8*). In a retrospective study evaluating nine children under 5 years of age whose mothers were later diagnosed with AIDS, two (22%) had antibody to HTLV-III/LAV (*9*). The infection status of these women during pregnancy was unknown.

In these studies, the rate of transmission ranged from 0% (0/3) to 65% (13/20). Additional studies are needed to better define the rate of transmission and variables associated with it.

Risk of Illness among Infected Pregnant Women. Pregnancy is associated with suppression of cell-mediated immunity and increased susceptibility to some infections (*10*). The T-helper to T-suppressor ratio is decreased during normal pregnancy, being lowest in the third trimester, and returns to normal approximately 3 months postpartum (*10*). It is not known whether pregnancy increases an infected woman's risk of developing AIDS or ARC, but one study suggests it does (*6*). Fifteen infected women who were well at time of delivery were followed an average of 30 months after the births of their children. Five (33%) subsequently developed AIDS; seven (47%) developed AIDS-related conditions; and only three (20%) remained asymptomatic. These results may not apply to all infected pregnant women, but they do suggest an increased likelihood of developing disease when an HTLV-III/LAV infection occurs in association with pregnancy.

HTLV-III/LAV – Continued

Prevalence of HTLV-III/LAV Infection. Counselling and testing for antibody to HTLV-III/LAV, when indicated, to reduce perinatal transmission of AIDS will be most beneficial in populations of women with increased prevalence of the virus (Table 1). These include: women who have used drugs intravenously for nonmedical purposes; women who were born in countries where heterosexual transmission is thought to play a major role (*11,12*); women who have engaged in prostitution; and women who are or have been sex partners of men who abuse IV drugs, are bisexual, have hemophilia, were born in countries where heterosexual transmission is thought to play a major role (*11,12*), or have evidence of HTLV-III/LAV infection.

The prevalence of antibody to HTLV-III/LAV in U.S. populations of men and women ranges from less than 0.01% in female blood donors to as high as 74% in men with hemophilia (*13-15*). Among heterosexual IV drug abusers, the prevalence of HTLV-III/LAV infection ranges from 2% to 59% in various geographic areas (*16,17*). Seroprevalence among the heterosexual partners of persons at increased risk for AIDS varies from 10% in female partners of asymptomatic, seropositive hemophilia patients to 71% in the female partners of men with AIDS or ARC (*18-20*). Among prostitutes, the HTLV-III/LAV antibody prevalence varies from 5% to 40%, depending on geographic area, with most of the women with positive tests relating histories of IV drug abuse (*21*). Among female blood donors in Atlanta, Georgia, who

TABLE 1. Prevalence of HTLV-III/LAV antibody in heterosexual populations — United States

Populations	Location	No. tested	Prevalence (%)
Intravenous drug abusers (*16,17*)	New York City	274	59
	NJ* < 5 miles from NYC†	204	56
	NJ 5-10 miles from NYC	124	43
	NJ > 100 miles from NYC	55	2
	San Francisco	53	9
Persons with hemophilia (*13,14*)			
Factor VIII concentrate recipients		234	74
Factor IX concentrate recipients		36	39
Cryoprecipitate only recipients		15	40
Female prostitutes (*21*)	Seattle, Washington	92	5
	Miami, Florida	25	40
Female sex partners of men with AIDS or ARC (two separate studies) (*19,20*)		7	71
		42	47
Female sex partners of men with asymptomatic HTLV-III/LAV infection (*18*)		21	10
Haitians (*12*)	New York City	97	4
	Miami, Florida	129	8
Female blood donors (*15*)	Atlanta, Georgia	28,354	0.01

*New Jersey.
†New York City.

HTLV-III/LAV – Continued

denied belonging to high-risk groups, 0.01% had repeatedly reactive enzyme-linked immunosorbent assays (ELISAs) followed by reactive Western blot tests (*15*).

Commercially available tests to detect antibody to HTLV-III/LAV are ELISAs using antigens derived from whole disrupted HTLV-III/LAV. When the ELISA is reactive on initial testing, it is standard procedure to repeat the test on the same specimen. Repeatedly reactive tests are highly sensitive and specific for antibody to HTLV-III/LAV. However, when the ELISA is used to screen populations in which the prevalence of infection is very low (such as blood donors or women not in high-risk groups), the proportion of repeatedly reactive results that are falsely positive will be higher. For that reason, an additional test, such as a Western blot, is recommended following repeatedly reactive ELISA results, especially in low-prevalence populations. In populations with high prevalence of infection (e.g. homosexual men or IV drug abusers), most repeatedly reactive ELISAs are reactive by Western blot or another test. For example, among 109 IV drug abusers whose sera were repeatedly reactive by ELISA, over 85% were reactive by Western blot (*22*). In contrast, in a low-prevalence population of 69 female blood donors whose sera were repeatedly reactive by ELISA, only 5% were reactive by Western blot (*15*).

Due to the seriousness of the implications of HTLV-III/LAV-antibody reactivity, it is recommended that repeatedly reactive ELISAs be followed by an additional test, such as the Western blot. Women with sera repeatedly reactive by ELISA and reactive by Western blot should have a thorough medical evaluation. HTLV-III/LAV has been isolated from a single specimen in 67%-95% of persons with specific antibody (*23,24*). Because infection has been demonstrated in asymptomatic persons, the presence of specific antibody should be considered presumptive evidence of current infection and infectiousness.

RECOMMENDATIONS

Women Who Should be Offered Counselling and Testing *Counselling services and testing for antibody to HTLV-III/LAV should be offered to pregnant women and women who may become pregnant in the following groups*: (1) those who have evidence of HTLV-III/LAV infection; (2) those who have used drugs intravenously for nonmedical purposes; (3) those who were born in countries where heterosexual transmission is thought to play a major role (*11,12*); (4) those who have engaged in prostitution; (5) those who are or have been sex partners of: IV drug abusers, bisexual men, men with hemophilia, men who were born in countries where heterosexual transmission is thought to play a major role (*11,12*), or men who otherwise have evidence of HTLV-III/LAV infection. If data become available to show that HTLV-III/LAV-antibody prevalence is increased in other groups or settings, counselling and testing programs should be extended to include them. Routine counselling and testing of women who are not included in the above-mentioned groups is not recommended due to low prevalence of infection and concern about interpretation of test results in a low-prevalence population. However if a woman requests it, the service should be provided in accordance with these recommendations.

Settings for Offering Counselling and Testing. Counselling and testing for antibody to HTLV-III/LAV to prevent perinatal transmission is recommended in the setting of any medical service in which women at increased risk are commonly encountered. These include services for treating IV drug abuse (i.e., detoxification and methadone maintenance), comprehensive hemophilia treatment centers, sexually transmitted disease clinics, and clinics that serve female prostitutes. In addition, services related to reproduction, such as family planning and infertility services, gynecologic, premarital, or preconceptual examinations, and prenatal and

HTLV-III/LAV – Continued

obstetric services should also consider offering counselling and testing if high-risk women are seen at these facilities. Testing for antibody to HTLV-III/LAV should be performed with the woman's consent after counselling is provided regarding risk factors for infection, the interpretation of test results, the risks of transmission, and the possible increased likelihood of disease among women infected with HTLV-III/LAV in association with pregnancy. The counselling and testing must be conducted in an environment in which confidentiality can be assured. In settings where confidential counselling and testing cannot be assured, information should be provided and referrals made to appropriate facilities.

Frequency of Testing. Detectable antibodies to HTLV-III/LAV may not develop until 2-4 months after exposure. This, and whether the woman is continuously exposed, should be taken into account when considering the need for, and frequency of, repeat testing. High-risk women should be offered counselling and testing before they become pregnant. During pregnancy, counselling and testing should be offered as soon as the woman is known to be pregnant. If the initial test is negative, repeat testing may be indicated near delivery to aid in the clinical management of the pregnant woman and newborn. If this final test is negative and the mother's risk of exposure no longer exists, she may safely consider breastfeeding the child, and management of the child need not include the same concerns that would be appropriate if the woman had had a positive test or if she were at high risk and had not been tested at all.

Counselling Women with Positive Results. Women with virologic or serologic evidence of HTLV-III/LAV infection should be counselled regarding their own risk of AIDS and the risk of perinatal and sexual transmission of HTLV-III/LAV. Infected women should be counselled to refer their sex partners for counselling and testing. If the partners of these women are not infected, both members of the couple should be counselled on how they may modify their sexual practices to reduce the risk of HTLV-III/LAV transmission to the uninfected partner. In addition, the couple should be told not to donate blood, organs, or sperm and should be discouraged from using IV drugs and advised against sharing needles and syringes. When seeking medical or dental care for intercurrent illness, they should inform those responsible for their care of their positive antibody status so appropriate evaluation can be undertaken. Recommendations for providing information and advice to individuals infected with HTLV-III/LAV have been published (*25*).

Infected women should be advised to consider delaying pregnancy until more is known about perinatal transmission of the virus. Pregnant infected women may require additional medical and social support services due to an enhanced risk of opportunistic infections and psychosocial difficulties during and after pregnancy. Obstetric-care providers should be alert to signs and symptoms of HTLV-III/LAV and related opportunistic infections in these pregnant women and to the need for specialized medical care.

HTLV-III/LAV-infected women should be advised against breastfeeding to avoid postnatal transmission to a child who may not yet be infected. The child should receive follow-up pediatric evaluations to determine whether he/she has HTLV-III/LAV infection, and to diagnose and treat promptly any diseases that may be secondary to HTLV-III/LAV infection. Recommendations for educating and providing foster care for infected children have been published (*26*).

Counselling Women with Negative Test Results. A negative ELISA for HTLV-III/LAV antibody in women who have no clinical or laboratory evidence of HTLV-III/LAV infection is evidence that they have probably not been infected. However, uninfected women who have sex

HTLV-III/LAV – Continued

partners with evidence of HTLV-III/LAV infection or with an increased risk of becoming infected should be informed that sexual intercourse increases their risk of infection. These women should be informed of the risks associated with pregnancy if they become infected and advised to consider delaying pregnancy until more is known about perinatal transmission of the virus or until they are no longer considered to be at risk for acquiring the virus. In addition to preventing pregnancy, the consistent and proper use of condoms can offer some protection against HTLV-III/LAV infection.

High-risk women, even if seronegative, should be told not to donate blood or organs. To decrease their risk of becoming infected, IV drug abusers should be encouraged to seek treatment for their drug abuse. Persons counselling IV drug abusers should know that IV drug abuse is often strongly ingrained and compulsive. Despite educational efforts and encouragement for treatment, some addicts will continue to abuse drugs or relapse after treatment. If drug abuse continues, they should be advised not to share needles or syringes and to use only sterile equipment.

(Continued on page 731)

TABLE I. Summary—cases of specified notifiable diseases, United States

Disease	48th Week Ending			Cumulative, 48th Week Ending		
	Nov. 30, 1985	Dec. 1, 1984	Median 1980-1984	Nov. 30, 1985	Dec. 1, 1984	Median 1980-1984
Acquired Immunodeficiency Syndrome (AIDS)	111	138	N	7,316	3,911	N
Aseptic meningitis	158	227	222	9,467	7,655	8,954
Encephalitis: Primary (arthropod-borne & unspec.)	7	22	23	1,173	1,098	1,430
Post-infectious	1	3	2	109	106	83
Gonorrhea: Civilian	10,908	15,535	16,913	775,020	777,626	882,338
Military	125	240	263	16,710	19,545	24,044
Hepatitis: Type A	497	455	476	21,040	19,907	21,145
Type B	505	550	486	24,188	23,993	20,172
Non A, Non B	58	80	N	3,721	3,520	N
Unspecified	105	103	168	5,286	4,746	7,986
Legionellosis	16	17	N	615	641	N
Leprosy	4	7	7	332	217	217
Malaria	12	10	21	935	921	985
Measles: Total*	14	15	15	2,628	2,516	2,516
Indigenous	14	12	N	2,191	2,222	N
Imported	-	3	N	437	294	N
Meningococcal infections: Total	38	55	49	2,165	2,461	2,508
Civilian	38	55	49	2,161	2,457	2,493
Military	-	-	-	4	4	14
Mumps	39	67	81	2,655	2,722	4,267
Pertussis	55	36	36	3,039	2,150	1,624
Rubella (German measles)	3	11	21	590	707	1,966
Syphilis (Primary & Secondary): Civilian	320	511	521	23,485	25,709	28,595
Military	3	3	5	132	271	351
Toxic Shock syndrome	6	5	N	324	436	N
Tuberculosis	320	499	515	19,621	19,558	23,485
Tularemia	2	4	4	156	276	260
Typhoid fever	6	4	8	350	345	428
Typhus fever, tick-borne (RMSF)	4	9	5	675	821	1,087
Rabies, animal	58	90	90	4,896	5,009	5,831

TABLE II. Notifiable diseases of low frequency, United States

	Cum. 1985		Cum. 1985
Anthrax	-	Leptospirosis	33
Botulism: Foodborne (Alaska 8)	51	Plague	16
Infant (Idaho 1)	60	Poliomyelitis: Total	5
Other	1	Paralytic	5
Brucellosis	125	Psittacosis (Ariz. 1)	102
Cholera	3	Rabies, human	1
Congenital rubella syndrome	-	Tetanus (Pa. 1)	67
Congenital syphilis, ages < 1 year	149	Trichinosis (Upstate N.Y. 1)	56
Diphtheria	2	Typhus fever, flea-borne (endemic, murine)	25

*There were no cases of internationally imported measles reported for this week.

TABLE III. Cases of specified notifiable diseases, United States, weeks ending November 30, 1985 and December 1, 1984 (48th Week)

Reporting Area	AIDS	Aseptic Menin-gitis	Encephalitis		Gonorrhea (Civilian)		Hepatitis (Viral), by type				Legionel-losis	Leprosy
			Primary	Post-in-fectious			A	B	NA,NB	Unspeci-fied		
	Cum 1985	1985	Cum 1985	Cum 1985	Cum 1985	Cum 1984	1985	1985	1985	1985	1985	Cum 1985
UNITED STATES	7,316	158	1,173	109	775,020	777,626	497	505	58	105	16	332
NEW ENGLAND	251	13	33	-	20,879	21,022	12	25	1	6	-	7
Maine	11	-	-	-	1,067	927	-	-	-	-	-	-
N H	3	-	7	-	523	682	-	-	-	-	-	-
Vt	2	-	-	-	307	356	-	-	-	-	-	-
Mass	149	6	18	-	8,636	8,924	11	12	1	5	-	7
R I	12	-	-	-	1,724	1,531	-	3	-	-	-	-
Conn	74	7	8	-	8,622	8,602	1	10	-	1	-	-
MID ATLANTIC	2,801	22	144	11	117,363	104,459	44	47	4	3	-	36
Upstate N Y	300	12	45	4	16,772	16,753	34	18	2	1	-	1
N Y City	1,925	1	16	-	56,466	40,502	-	-	-	-	-	31
N J	415	-	28	-	17,856	18,596	4	20	2	1	-	-
Pa	161	9	55	7	26,269	28,608	6	9	-	1	-	4
E N CENTRAL	333	17	342	20	107,001	110,884	17	43	4	5	2	21
Ohio	52	12	139	4	29,345	28,815	9	24	1	-	2	3
Ind	24	2	66	2	11,479	12,011	3	6	-	2	-	-
Ill	177	-	53	8	25,109	25,950	1	1	-	-	-	16
Mich	56	3	63	-	30,751	31,929	4	12	3	3	-	2
Wis	24	-	21	6	10,317	12,179	-	-	-	-	-	-
W N CENTRAL	106	7	75	4	38,249	38,164	9	15	1	1	-	2
Minn	35	2	36	1	5,649	5,748	3	7	1	-	-	1
Iowa	12	2	28	-	4,114	4,197	-	3	-	1	-	-
Mo	43	2	-	-	18,473	18,446	-	4	-	-	-	1
N Dak	1	-	-	1	254	362	-	-	-	-	-	-
S Dak	1	-	-	-	736	920	5	-	-	-	-	-
Nebr	3	-	5	-	3,258	2,759	-	-	-	-	-	-
Kans	11	1	6	2	5,765	5,732	1	1	-	-	-	-
S ATLANTIC	1,157	30	134	44	172,409	196,517	29	83	12	2	2	8
Del	10	1	8	-	4,125	3,748	3	-	-	-	-	-
Md	132	4	28	1	27,216	22,237	-	10	2	-	-	1
D C	165	-	-	-	14,663	14,088	-	7	-	-	-	-
Va	94	10	27	7	17,866	18,569	2	11	1	-	-	-
W Va	6	-	38	-	2,419	2,483	-	-	-	-	2	-
N C	59	5	27	1	33,800	31,770	3	6	2	-	-	2
S C	27	1	6	-	20,199	20,023	2	5	-	-	-	-
Ga	171	-	-	-	-	36,655	5	20	2	-	-	1
Fla	493	9	-	35	52,121	46,944	14	24	5	2	-	4
E S CENTRAL	66	15	37	4	70,881	70,673	3	39	2	2	1	-
Ky	17	4	17	-	8,111	8,396	1	3	-	-	-	-
Tenn	16	3	6	-	27,279	28,276	-	18	1	2	-	-
Ala	26	8	11	4	21,251	21,302	2	12	1	-	1	-
Miss	7	-	3	-	14,240	12,699	-	6	-	-	-	-
W S CENTRAL	519	18	137	2	102,509	104,676	64	47	3	33	4	31
Ark	10	-	7	1	9,670	9,575	1	4	1	1	-	1
La	86	-	9	-	19,579	22,803	-	-	-	-	-	7
Okla	16	2	24	1	11,547	11,579	4	3	-	3	2	-
Tex	407	16	97	-	61,713	60,719	59	40	2	29	2	23
MOUNTAIN	137	6	57	6	25,958	25,526	76	41	7	11	3	9
Mont	1	-	-	-	751	965	1	-	-	1	-	-
Idaho	1	-	-	-	895	1,195	2	-	1	-	-	-
Wyo	-	-	1	-	593	674	-	1	-	-	1	-
Colo	45	1	23	2	7,553	7,317	15	10	2	4	-	2
N Mex	13	3	3	-	2,879	3,070	7	6	-	-	-	-
Ariz	52	1	17	-	7,911	7,167	37	12	4	6	-	1
Utah	13	1	10	4	1,260	1,204	9	4	-	-	2	4
Nev	12	-	3	-	4,116	3,934	5	8	-	-	-	2
PACIFIC	1,946	30	214	18	119,771	105,705	243	165	24	42	4	218
Wash	108	1	13	1	9,127	8,331	18	13	7	1	-	37
Oreg	30	-	1	-	5,950	6,109	50	16	3	-	-	4
Calif	1,787	28	160	17	100,250	86,827	165	135	14	41	4	156
Alaska	3	-	40	-	2,871	2,655	-	1	-	-	-	-
Hawaii	18	1	-	-	1,573	1,783	10	-	-	-	-	21
Guam	1	U	-	-	161	221	U	U	U	U	U	3
P R	88	2	7	2	2,912	3,098	1	13	-	1	-	2
V I	2	U	-	-	369	487	U	U	U	U	U	-
Pac. Trust Terr.	-	U	-	-	146	-	U	U	U	U	U	20

N: Not notifiable U: Unavailable

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending November 30, 1985 and December 1, 1984 (48th Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin-gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported *		Total									
	Cum 1985	1985	Cum 1985	1985	Cum 1985	Cum 1984	Cum 1985	1985	Cum 1985	1985	Cum 1985	Cum 1984	1985	Cum 1985	Cum 1984
UNITED STATES	935	14	2,191	-	437	2,516	2,165	39	2,655	55	3,039	2,150	3	590	707
NEW ENGLAND	53	-	38	-	88	106	105	5	64	1	205	71	-	12	19
Maine	4	-	-	-	1	-	4	-	6	-	10	4	-	-	1
N H	5	-	-	-	-	36	15	-	11	-	112	17	-	2	1
Vt	1	-	-	-	-	7	10	-	3	-	3	23	-	-	-
Mass	25	-	34	-	84	49	21	4	21	1	47	19	-	6	16
R I	6	-	-	-	-	-	17	-	15	-	22	4	-	-	-
Conn	12	-	4	-	3	14	38	1	8	-	11	4	-	4	1
MID ATLANTIC	150	-	193	-	38	173	381	6	313	3	240	191	-	226	226
Upstate N Y	49	-	72	-	13	52	152	5	166	2	115	103	-	18	99
N Y City	59	-	67	-	12	109	65	-	33	-	27	16	-	185	103
N J	18	-	17	-	10	7	59	-	48	-	11	13	-	9	23
Pa	24	-	37	-	3	5	105	1	66	1	87	59	-	14	1
E N CENTRAL	60	-	443	-	90	697	375	5	916	8	712	490	-	34	100
Ohio	11	-	-	-	54	9	117	-	277	4	117	75	-	-	2
Ind	4	-	55	-	2	3	49	-	37	-	201	231	-	1	5
Ill	21	-	293	-	10	181	84	2	203	-	56	27	-	16	63
Mich	18	-	37	-	23	464	97	3	313	1	48	31	-	16	22
Wis	6	-	58	-	1	40	28	-	86	3	290	126	-	1	8
W N CENTRAL	33	-	2	-	10	58	107	1	84	4	233	124	-	19	39
Minn	16	-	-	-	6	47	27	-	1	-	117	16	-	2	4
Iowa	2	-	-	-	-	-	10	1	17	-	31	13	-	1	1
Mo	5	-	1	-	2	6	42	-	15	1	31	20	-	7	-
N Dak	2	-	-	-	2	-	5	-	4	-	10	-	-	2	3
S Dak	1	-	-	-	-	-	3	-	-	1	5	9	-	-	-
Nebr	1	-	-	-	-	-	9	-	3	2	10	12	-	7	31
Kans	6	-	1	-	-	5	11	-	44	-	29	54	-	56	28
S ATLANTIC	106	8	289	-	30	66	417	3	263	20	399	217	-	2	2
Del	-	-	-	-	-	-	11	-	1	-	2	2	-	6	1
Md	26	-	106	-	9	22	56	-	33	16	173	61	-	-	-
D C	8	-	9	-	1	8	7	-	-	-	1	-	-	2	1
Va	20	-	21	-	7	5	51	-	47	2	21	19	-	-	-
W Va	2	-	31	-	2	-	8	1	73	-	4	11	-	9	-
N C	9	-	9	-	-	1	56	-	19	1	34	35	-	1	-
S C	-	-	-	-	3	1	34	-	11	-	2	2	-	3	-
Ga	10	-	8	-	-	2	75	-	28	-	93	17	-	4	2
Fla	31	8	105	-	8	27	119	2	51	1	69	70	-	29	22
E S CENTRAL	11	-	-	-	7	6	96	-	30	3	67	14	-	3	12
Ky	4	-	-	-	5	1	9	-	8	-	8	2	-	3	6
Tenn	-	-	-	-	1	2	37	-	18	1	26	7	-	-	-
Ala	6	-	-	-	-	3	26	-	1	2	26	1	-	-	3
Miss	1	-	-	-	1	-	24	-	3	-	7	4	-	-	3
W S CENTRAL	93	4	425	-	15	621	185	8	302	9	527	334	2	41	66
Ark	3	-	-	-	-	8	19	-	7	-	14	22	-	1	3
La	1	-	42	-	-	8	25	-	2	-	17	10	-	-	-
Okla	7	-	-	-	1	8	33	N	N	-	160	243	-	1	-
Tex	82	4	383	-	14	597	108	8	293	9	336	59	2	39	63
MOUNTAIN	52	2	499	-	51	145	97	7	241	2	215	122	-	5	22
Mont	-	-	122	-	17	-	11	-	12	-	9	19	-	-	-
Idaho	3	-	126	-	18	23	5	-	9	1	9	7	-	1	1
Wyo	1	-	5	-	-	-	6	-	2	-	1	6	-	-	3
Colo	15	2	8	-	7	6	25	1	26	1	90	45	-	-	2
N Mex	15	-	1	-	5	88	13	N	N	-	13	12	-	2	1
Ariz	11	-	237	-	4	1	22	6	121	-	40	24	-	1	4
Utah	2	-	-	-	-	27	9	-	6	-	53	7	-	-	7
Nev	5	-	-	-	-	-	6	-	65	-	-	2	-	1	4
PACIFIC	377	-	302	-	108	644	402	4	442	5	341	587	1	194	195
Wash	23	-	90	-	39	154	66	-	35	2	82	322	-	14	1
Oreg	14	-	4	-	1	-	35	N	N	1	50	30	-	2	2
Calif	321	-	190	-	63	327	280	4	379	2	262	157	1	135	185
Alaska	2	-	-	-	-	-	9	-	9	-	30	3	-	1	1
Hawaii	17	-	18	-	5	163	12	-	19	-	17	75	-	42	6
Guam	1	U	10	U	1	90	-	U	6	U	-	-	U	2	4
P R	-	-	67	-	-	212	14	3	155	2	15	1	-	27	20
V I	-	U	4	U	6	-	-	U	3	U	-	-	U	-	-
Pac Trust Terr	-	U	-	U	-	-	-	U	3	U	-	-	U	-	-

*For measles only, imported cases includes both out-of-state and international importations.

N Not notifiable U Unavailable †International §Out-of-state

TABLE III. (Cont'd.) Cases of specified notifiable diseases, United States, weeks ending November 30, 1985 and December 1, 1984 (48th Week)

Reporting Area	Syphilis (Civilian) (Primary & Secondary)		Toxic-shock Syndrome	Tuberculosis		Tula-remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum 1985	Cum 1984	1985	Cum 1985	Cum 1984	Cum 1985	Cum 1985	Cum 1985	Cum 1985
UNITED STATES	23,485	25,709	6	19,621	19,558	156	350	675	4,896
NEW ENGLAND	547	493	-	663	585	4	14	9	20
Maine	15	10	-	44	30	-	-	-	-
N.H.	38	14	-	20	27	-	1	1	1
Vt.	5	1	-	8	7	-	-	-	1
Mass.	270	277	-	391	319	4	10	6	11
R.I.	17	22	-	50	48	-	-	1	-
Conn.	202	169	-	150	154	-	3	1	7
MID ATLANTIC	3,322	3,455	-	3,499	3,563	2	53	37	591
Upstate N.Y.	244	305	-	600	542	-	14	9	139
N.Y. City	2,004	2,064	-	1,715	1,480	1	27	5	-
N.J.	643	610	-	476	787	1	11	4	39
Pa.	431	476	-	708	754	-	1	19	413
E.N. CENTRAL	908	1,264	-	2,408	2,555	3	43	39	170
Ohio	135	218	-	410	455	-	11	23	28
Ind.	75	126	-	309	315	-	3	5	23
Ill.	414	502	-	1,046	1,065	2	19	9	38
Mich.	224	346	-	509	572	-	8	2	25
Wis.	60	72	-	134	148	1	2	-	56
W.N. CENTRAL	222	334	1	562	595	48	13	42	867
Minn.	42	86	-	120	105	1	6	-	175
Iowa	18	11	1	53	62	-	3	1	142
Mo.	126	170	-	269	295	31	3	7	48
N. Dak.	2	9	-	9	13	-	-	1	128
S. Dak.	6	1	-	31	22	8	-	2	294
Nebr.	6	15	-	12	30	2	1	4	34
Kans.	22	42	-	68	68	6	-	27	46
S. ATLANTIC	5,778	7,514	2	4,033	4,079	6	42	320	1,234
Del.	36	19	-	41	52	1	-	3	1
Md.	416	444	-	362	374	-	11	26	626
D.C.	306	316	-	141	161	-	-	-	-
Va.	282	388	-	406	400	1	3	25	169
W. Va.	25	20	-	102	127	-	1	2	28
N.C.	631	799	1	539	616	4	4	133	12
S.C.	743	718	-	489	497	-	3	71	59
Ga.	-	1,311	1	677	637	-	3	48	196
Fla.	3,339	3,499	-	1,276	1,215	-	17	12	143
E.S. CENTRAL	2,039	1,852	-	1,694	1,836	9	5	77	233
Ky.	65	92	-	414	436	-	1	15	34
Tenn.	592	480	-	502	532	7	2	33	72
Ala.	611	625	-	499	536	1	2	15	120
Miss.	771	655	-	279	332	1	-	14	7
W.S. CENTRAL	5,673	6,278	1	2,485	2,315	61	32	134	809
Ark.	308	200	-	286	263	36	-	16	136
La.	1,008	1,098	-	352	337	-	1	4	19
Okla.	178	197	-	236	221	19	2	90	103
Tex.	4,179	4,783	1	1,611	1,494	6	29	24	551
MOUNTAIN	714	627	-	526	530	15	13	14	437
Mont.	6	3	-	46	17	4	-	6	223
Idaho	7	23	-	25	28	-	-	-	10
Wyo.	13	7	-	7	4	-	-	4	33
Colo.	201	169	-	82	66	2	5	2	25
N. Mex.	121	88	-	83	100	2	4	-	12
Ariz.	297	227	-	230	243	4	3	-	119
Utah	9	18	-	17	35	3	1	-	4
Nev.	60	92	-	36	37	-	-	2	11
PACIFIC	4,282	3,892	2	3,751	3,500	8	135	3	535
Wash.	97	141	-	214	184	-	1	-	4
Oreg.	100	106	-	124	141	1	5	-	4
Calif.	4,014	3,566	2	3,141	2,901	4	123	3	524
Alaska	4	6	-	95	74	3	2	-	3
Hawaii	67	73	-	177	200	-	4	-	-
Guam	2	-	U	35	50	-	3	-	-
P.R.	813	733	-	330	359	-	4	-	34
V.I.	3	11	U	1	4	-	52	-	-
Pac. Trust Terr.	13	-	U	16	-	-	-	-	-

U: Unavailable

TABLE IV. Deaths in 121 U.S. cities,* week ending November 30, 1985 (48th Week)

Reporting Area	All Causes, By Age (Years)						P&I** Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	489	352	89	28	6	14	48
Boston, Mass	95	48	30	9	3	5	11
Bridgeport, Conn	40	29	9	-	1	1	2
Cambridge, Mass	23	17	3	3	-	-	2
Fall River, Mass	17	16	-	1	-	-	-
Hartford, Conn	44	30	9	2	2	1	2
Lowell, Mass	27	19	7	1	-	-	1
Lynn, Mass	16	13	3	-	-	-	4
New Bedford, Mass	20	14	3	2	-	1	3
New Haven, Conn §	37	35	1	-	-	1	2
Providence, R I	47	39	2	4	-	2	6
Somerville, Mass	2	1	1	-	-	-	-
Springfield, Mass	41	30	8	2	-	1	7
Waterbury, Conn	30	22	5	3	-	-	6
Worcester, Mass	50	39	8	1	-	2	2
MID ATLANTIC	2,309	1,541	488	185	51	44	99
Albany, N Y	64	46	13	1	3	1	2
Allentown, Pa	17	15	2	-	-	-	-
Buffalo, N Y	108	74	25	6	-	3	9
Camden, N J	28	21	7	-	-	-	1
Elizabeth, N J	18	16	2	-	-	-	1
Erie, Pa †	37	27	9	1	-	-	2
Jersey City, N J	40	21	12	6	-	1	-
N Y City, N Y	1,203	789	234	132	27	21	51
Newark, N J	15	8	5	2	-	-	3
Paterson, N J	31	14	11	3	-	3	1
Philadelphia, Pa	297	197	69	14	9	8	13
Pittsburgh, Pa †	61	40	13	4	4	-	2
Reading, Pa	33	25	7	-	-	1	2
Rochester, N Y	111	74	26	7	4	-	5
Schenectady, N Y	38	29	6	1	-	2	1
Scranton, Pa †	23	17	6	-	-	-	-
Syracuse, N Y	100	69	22	4	3	2	1
Trenton, N J	27	18	7	-	-	2	-
Utica, N Y	27	18	7	1	1	-	3
Yonkers, N Y	31	23	5	3	-	-	2
E N CENTRAL	1,952	1,383	307	115	66	80	88
Akron, Ohio	31	23	6	1	-	1	1
Canton, Ohio	44	29	10	3	1	1	4
Chicago, Ill §	553	462	11	26	16	37	16
Cincinnati, Ohio	127	77	32	10	3	5	7
Cleveland, Ohio	157	87	43	13	4	10	4
Columbus, Ohio	132	81	32	12	5	2	7
Dayton, Ohio	83	58	20	2	3	-	2
Detroit, Mich	155	107	24	14	9	1	1
Evansville, Ind	35	26	6	1	2	-	2
Fort Wayne, Ind	26	17	4	2	2	1	1
Gary, Ind	9	6	1	2	-	-	-
Grand Rapids, Mich	63	42	15	2	3	1	4
Indianapolis, Ind	150	89	35	10	7	9	2
Madison, Wis	35	27	2	3	1	2	4
Milwaukee, Wis	89	67	12	2	3	5	4
Peoria, Ill	33	30	3	-	-	-	3
Rockford, Ill	28	19	4	1	1	3	6
South Bend, Ind	30	23	5	2	-	-	5
Toledo, Ohio	103	66	26	7	3	1	11
Youngstown, Ohio	69	47	16	2	3	1	2
W N CENTRAL	577	397	100	34	24	21	33
Des Moines, Iowa	48	32	10	2	2	2	6
Duluth, Minn	9	7	1	-	1	-	-
Kansas City, Kans	37	20	6	4	3	3	4
Kansas City, Mo	116	85	23	6	1	1	2
Lincoln, Nebr	28	17	7	3	-	1	1
Minneapolis, Minn	61	40	4	4	8	5	2
Omaha, Nebr	59	42	11	2	2	2	4
St Louis, Mo	133	100	22	3	2	6	10
St Paul, Minn	42	27	9	4	1	1	1
Wichita, Kans	44	27	7	6	4	-	3
S ATLANTIC	1,173	713	272	88	35	65	46
Atlanta, Ga	109	58	31	9	7	4	-
Baltimore, Md	259	155	50	24	10	20	12
Charlotte, N C	74	42	21	6	2	3	6
Jacksonville, Fla	60	42	15	1	-	2	2
Miami, Fla	145	89	39	11	2	4	-
Norfolk, Va	47	24	8	3	4	8	6
Richmond, Va	59	38	13	4	2	2	4
Savannah, Ga	51	37	12	1	-	1	3
St Petersburg, Fla	91	66	14	5	1	5	4
Tampa, Fla	57	35	10	6	1	5	3
Washington, D C	194	107	53	17	6	11	5
Wilmington, Del	27	20	6	1	-	-	1
E S CENTRAL	613	383	138	30	24	38	37
Birmingham, Ala	122	71	31	7	6	7	4
Chattanooga, Tenn	57	45	10	1	1	-	5
Knoxville, Tenn	75	53	16	3	2	1	3
Louisville, Ky	101	66	29	3	2	1	12
Memphis, Tenn	123	70	22	5	4	22	7
Mobile, Ala	45	28	8	2	5	2	2
Montgomery, Ala	21	12	6	2	1	-	-
Nashville, Tenn	69	38	16	7	3	5	4
W S CENTRAL	960	559	232	95	40	34	45
Austin, Tex	41	25	6	3	2	5	3
Baton Rouge, La	37	21	8	3	2	3	2
Corpus Christi, Tex	44	25	10	7	1	1	3
Dallas, Tex	114	61	27	19	5	2	7
El Paso, Tex	36	25	8	1	1	1	-
Fort Worth, Tex	78	40	19	8	8	3	4
Houston, Tex	291	159	82	27	10	13	4
Little Rock, Ark	22	14	4	3	-	1	4
New Orleans, La	77	48	20	7	2	-	1
San Antonio, Tex	120	70	28	13	6	3	9
Shreveport, La	48	36	10	1	1	-	5
Tulsa, Okla	52	35	10	3	2	2	3
MOUNTAIN	565	374	107	50	20	14	40
Albuquerque, N Mex	71	45	16	6	1	3	5
Colo Springs, Colo	26	18	6	1	-	1	6
Denver, Colo	92	71	14	6	1	-	7
Las Vegas, Nev	87	45	26	11	4	1	8
Ogden, Utah	20	12	3	4	1	-	2
Phoenix, Ariz	89	57	16	8	4	4	4
Pueblo, Colo	24	19	2	3	-	-	1
Salt Lake City, Utah	54	35	7	7	3	2	-
Tucson, Ariz	102	72	17	4	6	3	7
PACIFIC	1,719	1,127	317	146	55	66	107
Berkeley, Calif	23	16	4	3	-	-	2
Fresno, Calif	90	59	19	7	1	4	10
Glendale, Calif	15	11	3	-	-	1	1
Honolulu, Hawaii	57	39	13	2	1	2	8
Long Beach, Calif	89	53	15	9	4	8	14
Los Angeles, Calif	379	247	67	40	13	6	6
Oakland, Calif	74	53	12	6	-	3	4
Pasadena, Calif	14	9	1	-	1	3	-
Portland, Oreg	136	104	17	8	4	3	8
Sacramento, Calif	146	95	35	11	2	3	14
San Diego, Calif	148	95	30	10	4	7	11
San Francisco, Calif	167	98	35	24	5	5	4
San Jose, Calif	167	106	33	11	7	10	13
Seattle, Wash	121	75	20	10	9	7	4
Spokane, Wash	53	41	6	2	2	2	7
Tacoma, Wash	40	26	7	3	2	2	1
TOTAL	10,357 ††	6,829	2,050	771	321	376	541

* Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

** Pneumonia and influenza.

† Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

†† Total includes unknown ages.

§ Data not available. Figures are estimates based on average of past 4 weeks.

HTLV-III/LAV – Continued

Additional Considerations. These recommendations will be revised as additional information becomes available. It is recognized that provision of the recommended professional counselling, HTLV-III/LAV-antibody testing and associated specialized medical services will take time to implement and may stress available resources, particularly in public facilities, which are most greatly affected. Health-care providers, social-service personnel, and others involved in educating and caring for HTLV-III/LAV-infected persons should be aware of the potential for social isolation and should be sensitive to the need for confidentiality. They should be familiar with federal and state laws, regulations, and policies that protect the confidentiality of clinical data and test results. Each institution should assure that specific mechanisms are in place to protect the confidentiality of all records and to prevent the misuse of information. Anonymous testing would not be appropriate if it prevents adequate counselling and medical follow-up evaluation.

Hospital precautions for managing infected women and infants should be patterned after those for caring for patients with HTLV-III/LAV infection (*27,28*). Additional recommendations will follow.

DEVELOPMENT OF THESE RECOMMENDATIONS

The information and recommendations contained in this document were developed and compiled by CDC and the U.S. Public Health Service in consultation with individuals representing: the Conference of State and Territorial Epidemiologists, the Association of State and Territorial Health Officials, the American Public Health Association, the United States Conference of Local Health Officers, the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the Planned Parenthood Federation of America, the American Venereal Disease Association, the Division of Maternal and Child Health of the Health Resources and Services Administration, the National Institute on Drug Abuse of the Alcohol, Drug Abuse, and Mental Health Administration, the National Hemophilia Foundation, the Haitian Medical Association, the American Bar Foundation, and the Kennedy Institute of Ethics at Georgetown University. The consultants also included representatives of the departments of health of the areas with the largest number of perinatally transmitted pediatric AIDS cases: New York City, Florida, and New Jersey. These recommendations may not reflect the views of all individual consultants or the organizations they represented.

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HTLV-III/LAV – Continued

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Epidemiologic Notes and Reports

Mucuna pruriens-Associated Pruritus — New Jersey

On October 6, 1985, a Paterson, New Jersey, Fire Department ambulance responded to a call reporting two people with severe pruritus. On arrival, the two emergency medical technicians (EMTs) found a Spanish-speaking couple living above a beauty salon who described

Pruritus – Continued

severe itching, which they attributed to "voodoo beans" found in their beds. They displayed several fuzzy bean pods. Soon after their arrival, the EMTs developed pruritus. All four individuals went to an emergency room complaining of itching and skin discomfort. On examination, both members of the couple had erythematous macular rashes on their extremities and bodies; the EMTs had rashes on their arms. There were no respiratory problems. Because of the unknown etiology of the symptoms, two were given epinephrine injections, the others received antihistamines and topical steroid cream. Symptoms resolved within 1-2 hours of treatment. The admitting nurse, who put an arm around one patient, developed a pruritic erythematous area on her inner forearm approximately 20 minutes later. This resolved an hour after washing her skin with soap and water. A policeman who went to the apartment and a worker who collected trash outside the following day also developed itching and received similar emergency-room treatment. Patrons and employees of the shop below and neighbors of the couple had no similar symptoms over the 2-day period.

An industrial hygienist with the local health department went to the site in complete protective gear to look for possible chemical contamination from the beauty salon. Visual inspection and screens for ionizable organic vapors were negative, but he retrieved another bean pod. The botanical samples were sent to Rutgers University, where the plant was identified as *Mucuna pruriens*. Recommended decontamination procedures for the apartment included steam cleaning of all fabrics and rugs, HEPA Vac cleaning of floors and countertops, and destruction of any fabrics that could not be cleaned.

Reported by D Fairbrothers, MD, E Kirby, MD, Rutgers University, New Brunswick, Barnert Memorial Hospital Center, Paterson, RM Lester, PC Wegmann, Paterson Div of Health, F Marshall, WE Parkin, DVM, State Epidemiologist, New Jersey Dept of Health, Div of Field Svcs, Epidemiology Program Office, CDC.

Editorial Note: *Mucuna pruriens*, a legume known from Medieval Latin botanical works with the Latin synonym *Stizolobium pruriens* (*1*), was first described in the English literature in 1804. The plant is variously called cowitch, cowhage (derived from the Hindu name, "kiwach" or "bad rubbing"), kaunch, and pica-pica (*2*), the common names are not specific. It grows wild in the tropics, including India, and tropical islands, including the Bahamas (*3,4*), its range may extend to southern Florida.

Each 10- to 13-cm fruiting pod bears approximately 5,000 barbed, easily detachable spicules measuring 2 mm by 20 μm that cause dermatitis through an inflammatory response, presumably an immediate hypersensitivity reaction. Hairs from dried pods, as in herbarium specimens, remain potent (*5*). The spicules have been sold commercially as itching powder and, at least through 1950, as an oral vermifuge (*1,6*).

In 1955, studies showed that introduction of one spicule through the epidermis with friction or pressure led to a burning itch lasting up to 30 minutes (*1*). Spicules could be removed from the skin by washing or by applying an adhesive tape. Mucunain, a protein with endopeptidase and dipeptidase activity, was identified as the active pruritic agent. The protein was extractable only from spicules using aqueous solutions and could be inactivated by autoclaving, changing the pH, or using a similar denaturing process that did not change the spicule structure. Further investigations confirmed the biochemical nature of the pruritic agent, identified as a thermolabile protein of molecular weight 40,000 (*7*).

Emergency-room personnel should be alert to the possibility that members of some subcultures in this country may be exposed to *Mucuna pruriens*. Pods and contaminated fabrics should be handled with caution. Symptoms resolve spontaneously within several hours, but antihistaminic therapy appears to be effective for faster resolution.

Pruritus – Continued

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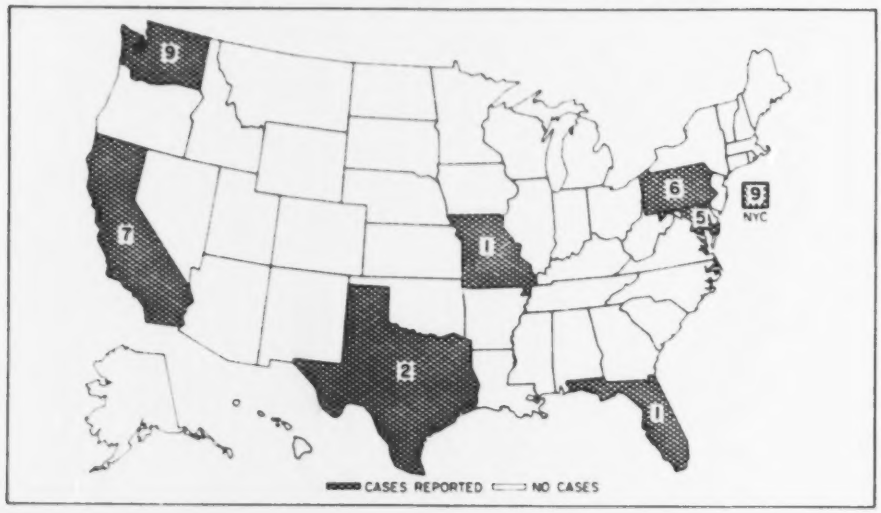
Influenza Outbreaks — Alaska

Alaska state health officials reported outbreaks of influenza-like illness in most areas of the state during the last 2 weeks of November. Although physicians have noted cases in adults, most cases have been reported in schoolchildren. Absentee rates in excess of 20% have been reported in schools located near Anchorage, Fairbanks, and Juneau in association with increased influenza-like illness among students.

Preliminary laboratory testing identified six type A(H3N2) influenza viruses in specimens collected from patients in Anchorage and Fairbanks, where sporadic influenza was reported from late September to mid-October. Laboratory identification of viral isolates from the recent outbreaks is pending.

Reported by D Ritter, L Curtin, Northern Regional Laboratory, JP Middaugh, MD, State Epidemiologist, Div of Public Health, Alaska Dept of Health and Social Svcs; Div of Field Svcs, Epidemiology Program Office; Influenza Br, Div of Viral Diseases, Center for Infectious Diseases, CDC.

FIGURE I. Reported measles cases — United States, weeks 44-47, 1985



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The data in this report are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the succeeding Friday.

The editor welcomes accounts of interesting cases, outbreaks, environmental hazards, or other public health problems of current interest to health officials. Such reports and any other matters pertaining to editorial or other textual considerations should be addressed to: ATTN: Editor, *Morbidity and Mortality Weekly Report*, Centers for Disease Control, Atlanta, Georgia 30333.

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MORBIDITY AND MORTALITY WEEKLY REPORT

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681 Summary: Recommendations for Preventing Transmission of Infection with HTLV-III/LAV in the Workplace
682 Recommendations for Preventing Transmission of Infection with HTLV-III/LAV in the Workplace

Current Trends

Summary: Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus in the Workplace

The information and recommendations contained in this document have been developed with particular emphasis on health-care workers and others in related occupations in which exposure might occur to blood from persons infected with HTLV-III/LAV, the "AIDS virus." Because of public concern about the purported risk of transmission of HTLV-III/LAV by persons providing personal services and those preparing and serving food and beverages, this document also addresses personal-service and food-service workers. Finally, it addresses "other workers"—persons in settings, such as offices, schools, factories, and construction sites, where there is no known risk of AIDS virus transmission.

Because AIDS is a bloodborne, sexually transmitted disease that is not spread by casual contact, this document does *not* recommend routine HTLV-III/LAV antibody screening for the groups addressed. Because AIDS is not transmitted through preparation or serving of food and beverages, these recommendations state that food-service workers known to be infected with AIDS should not be restricted from work unless they have another infection or illness for which such restriction would be warranted.

This document contains detailed recommendations for precautions appropriate to prevent transmission of all bloodborne infectious diseases to people exposed—in the course of their duties—to blood from persons who may be infected with HTLV-III/LAV. They emphasize that health-care workers should take all possible precautions to prevent needlestick injury. The recommendations are based on the well-documented modes of HTLV-III/LAV transmission and incorporate a "worst case" scenario, the hepatitis B model of transmission. Because the hepatitis B virus is also bloodborne and is both hardier and more infectious than HTLV-III/LAV, recommendations that would prevent transmission of hepatitis B will also prevent transmission of AIDS.

Formulation of specific recommendations for health-care workers who perform invasive procedures is in progress.

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from some other body fluids, secretions, and excretions, but epidemiologic evidence has implicated only blood and semen in transmission. Studies of nonsexual household contacts of AIDS patients indicate that casual contact with saliva and tears does not result in transmission of infection. Spread of infection to household contacts of infected persons has not been detected when the household contacts have not been sex partners or have not been infants of infected mothers. The kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HTLV-III/LAV.

As in the development of any such recommendations, the paramount consideration is the protection of the public's health. The following recommendations have been developed for all workers, particularly workers in occupations in which exposure might occur to blood from individuals infected with HTLV-III/LAV. These recommendations reinforce and supplement the specific recommendations that were published earlier for clinical and laboratory staffs (*1*) and for dental-care personnel and persons performing necropsies and morticians' services (*2*). Because of public concern about the purported risk of transmission of HTLV-III/LAV by persons providing personal services and by food and beverages, these recommendations contain information and recommendations for personal-service and food-service workers. Finally, these recommendations address workplaces in general where there is no known risk of transmission of HTLV-III/LAV (e.g., offices, schools, factories, construction sites). Formulation of specific recommendations for health-care workers (HCWs) who perform invasive procedures (e.g., surgeons, dentists) is in progress. Separate recommendations are also being developed to prevent HTLV-III/LAV transmission in prisons, other correctional facilities, and institutions housing individuals who may exhibit uncontrollable behavior (e.g., custodial institutions) and in the perinatal setting. In addition, separate recommendations have already been developed for children in schools and day-care centers (*3*).

HTLV-III/LAV-infected individuals include those with AIDS (*4*); those diagnosed by their physician(s) as having other illnesses due to infection with HTLV-III/LAV; and those who have virologic or serologic evidence of infection with HTLV-III/LAV but who are not ill.

These recommendations are based on the well-documented modes of HTLV-III/LAV transmission identified in epidemiologic studies and on comparison with the hepatitis B experience. Other recommendations are based on the hepatitis B model of transmission.

COMPARISON WITH THE HEPATITIS B VIRUS EXPERIENCE

The epidemiology of HTLV-III/LAV infection is similar to that of hepatitis B virus (HBV) infection, and much that has been learned over the last 15 years related to the risk of acquiring hepatitis B in the workplace can be applied to understanding the risk of HTLV-III/LAV transmission in the health-care and other occupational settings. Both viruses are transmitted through

HTLV-III/LAV – Continued

sexual contact, parenteral exposure to contaminated blood or blood products, and perinatal transmission from infected mothers to their offspring. Thus, some of the same major groups at high risk for HBV infection (e.g., homosexual men, IV drug abusers, persons with hemophilia, infants born to infected mothers) are also the groups at highest risk for HTLV-III/LAV infection. Neither HBV nor HTLV-III/LAV has been shown to be transmitted by casual contact in the workplace, contaminated food or water, or airborne or fecal-oral routes (*5*).

HBV infection is an occupational risk for HCWs, but this risk is related to degree of contact with blood or contaminated needles. HCWs who do not have contact with blood or needles contaminated with blood are not at risk for acquiring HBV infection in the workplace (*6-8*).

In the health-care setting, HBV transmission has not been documented between hospitalized patients, except in hemodialysis units, where blood contamination of the environment has been extensive or where HBV-positive blood from one patient has been transferred to another patient through contamination of instruments. Evidence of HBV transmission from HCWs to patients has been rare and limited to situations in which the HCWs exhibited high concentrations of virus in their blood (at least 100,000,000 infectious virus particles per ml of serum), and the HCWs sustained a puncture wound while performing traumatic procedures on patients or had exudative or weeping lesions that allowed virus to contaminate instruments or open wounds of patients (*9-11*).

Current evidence indicates that, despite epidemiologic similarities of HBV and HTLV-III/LAV infection, the risk for HBV transmission in health-care settings far exceeds that for HTLV-III/LAV transmission. The risk of acquiring HBV infection following a needlestick from an HBV carrier ranges from 6% to 30% (*12,13*), far in excess of the risk of HTLV-III/LAV infection following a needlestick involving a source patient infected with HTLV-III/LAV, which is less than 1%. In addition, all HCWs who have been shown to transmit HBV infection in health-care settings have belonged to the subset of chronic HBV carriers who, when tested, have exhibited evidence of exceptionally high concentrations of virus (at least 100,000,000 infectious virus particles per ml) in their blood. Chronic carriers who have substantially lower concentrations of virus in their blood have not been implicated in transmission in the health-care setting (*9-11,14*). The HBV model thus represents a "worst case" condition in regard to transmission in health-care and other related settings. Therefore, recommendations for the control of HBV infection should, if followed, also effectively prevent spread of HTLV-III/LAV. Whether additional measures are indicated for those HCWs who perform invasive procedures will be addressed in the recommendations currently being developed.

Routine screening of all patients or HCWs for evidence of HBV infection has never been recommended. Control of HBV transmission in the health-care setting has emphasized the implementation of recommendations for the appropriate handling of blood, other body fluids, and items soiled with blood or other body fluids.

TRANSMISSION FROM PATIENTS TO HEALTH-CARE WORKERS

HCWs include, but are not limited to, nurses, physicians, dentists and other dental workers, optometrists, podiatrists, chiropractors, laboratory and blood bank technologists and technicians, phlebotomists, dialysis personnel, paramedics, emergency medical technicians, medical examiners, morticians, housekeepers, laundry workers, and others whose work involves contact with patients, their blood or other body fluids, or corpses.

Recommendations for HCWs emphasize precautions appropriate for preventing transmission of bloodborne infectious diseases, including HTLV-III/LAV and HBV infections. Thus, these precautions should be enforced routinely, as should other standard infection-control precautions, regardless of whether HCWs or patients are known to be infected with HTLV-III/LAV or HBV. In addition to being informed of these precautions, all HCWs, including students

HTLV-III/LAV – Continued

and housestaff, should be educated regarding the epidemiology, modes of transmission, and prevention of HTLV-III/LAV infection.

Risk of HCWs acquiring HTLV-III/LAV in the workplace. Using the HBV model, the highest risk for transmission of HTLV-III/LAV in the workplace would involve parenteral exposure to a needle or other sharp instrument contaminated with blood of an infected patient. The risk to HCWs of acquiring HTLV-III/LAV infection in the workplace has been evaluated in several studies. In five separate studies, a total of 1,498 HCWs have been tested for antibody to HTLV-III/LAV. In these studies, 666 (44.5%) of the HCWs had direct parenteral (needlestick or cut) or mucous membrane exposure to patients with AIDS or HTLV-III/LAV infection. Most of these exposures were to blood rather than to other body fluids. None of the HCWs whose initial serologic tests were negative developed subsequent evidence of HTLV-III/LAV infection following their exposures. Twenty-six HCWs in these five studies were seropositive when first tested; all but three of these persons belonged to groups recognized to be at increased risk for AIDS (*15*). Since one was tested anonymously, epidemiologic information was available on only two of these three seropositive HCWs. Although these two HCWs were reported as probable occupationally related HTLV-III/LAV infection (*15,16*), neither had a preexposure nor an early postexposure serum sample available to help determine the onset of infection. One case reported from England describes a nurse who seroconverted following an accidental parenteral exposure to a needle contaminated with blood from an AIDS patient (*17*).

In spite of the extremely low risk of transmission of HTLV-III/LAV infection, even when needlestick injuries occur, more emphasis must be given to precautions targeted to prevent needlestick injuries in HCWs caring for any patient, since such injuries continue to occur even during the care of patients who are known to be infected with HTLV-III/LAV.

Precautions to prevent acquisition of HTLV-III/LAV infection by HCWs in the workplace. These precautions represent prudent practices that apply to preventing transmission of HTLV-III/LAV and other bloodborne infections and should be used routinely (*18*).

1. Sharp items (needles, scalpel blades, and other sharp instruments) should be considered as potentially infective and be handled with extraordinary care to prevent accidental injuries.
2. Disposable syringes and needles, scalpel blades, and other sharp items should be placed into puncture-resistant containers located as close as practical to the area in which they were used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand.
3. When the possibility of exposure to blood or other body fluids exists, routinely recommended precautions should be followed. The anticipated exposure may require gloves alone, as in handling items soiled with blood or equipment contaminated with blood or other body fluids, or may also require gowns, masks, and eye-coverings when performing procedures involving more extensive contact with blood or potentially infective body fluids, as in some dental or endoscopic procedures or postmortem examinations. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood.
4. To minimize the need for emergency mouth-to-mouth resuscitation, mouth pieces, resuscitation bags, or other ventilation devices should be strategically located and available for use in areas where the need for resuscitation is predictable.
5. Pregnant HCWs are not known to be at greater risk of contracting HTLV-III/LAV infections than HCWs who are not pregnant; however, if a HCW develops HTLV-III/LAV infection during pregnancy, the infant is at increased risk of infection resulting from

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perinatal transmission. Because of this risk, pregnant HCWs should be especially familiar with precautions for the preventing HTLV-III/LAV transmission (*19*).

Precautions for HCWs during home care of persons infected with HTLV-III/LAV. Persons infected with HTLV-III/LAV can be safely cared for in home environments. Studies of family members of patients infected with HTLV-III/LAV have found no evidence of HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to children who were not at risk for perinatal transmission (*3*). HCWs providing home care face the same risk of transmission of infection as HCWs in hospitals and other health-care settings, especially if there are needlesticks or other parenteral or mucous membrane exposures to blood or other body fluids.

When providing health-care service in the home to persons infected with HTLV-III/LAV, measures similar to those used in hospitals are appropriate. As in the hospital, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand. Needles and other sharp items should be placed into puncture-resistant containers and disposed of in accordance with local regulations for solid waste. Blood and other body fluids can be flushed down the toilet. Other items for disposal that are contaminated with blood or other body fluids that cannot be flushed down the toilet should be wrapped securely in a plastic bag that is impervious and sturdy (not easily penetrated). It should be placed in a second bag before being discarded in a manner consistent with local regulations for solid waste disposal. Spills of blood or other body fluids should be cleaned with soap and water or a household detergent. As in the hospital, individuals cleaning up such spills should wear disposable gloves. A disinfectant solution or a freshly prepared solution of sodium hypochlorite (household bleach, see below) should be used to wipe the area after cleaning.

Precautions for providers of prehospital emergency health care. Providers of prehospital emergency health care include the following: paramedics, emergency medical technicians, law enforcement personnel, firefighters, lifeguards, and others whose job might require them to provide first-response medical care. The risk of transmission of infection, including HTLV-III/LAV infection, from infected persons to providers of prehospital emergency health care should be no higher than that for HCWs providing emergency care in the hospital if appropriate precautions are taken to prevent exposure to blood or other body fluids.

Providers of prehospital emergency health care should follow the precautions outlined above for other HCWs. No transmission of HBV infection during mouth-to-mouth resuscitation has been documented. However, because of the theoretical risk of salivary transmission of HTLV-III/LAV during mouth-to-mouth resuscitation, special attention should be given to the use of disposable airway equipment or resuscitation bags and the wearing of gloves when in contact with blood or other body fluids. Resuscitation equipment and devices known or suspected to be contaminated with blood or other body fluids should be used once and disposed of or be thoroughly cleaned and disinfected after each use.

Management of parenteral and mucous membrane exposures of HCWs. If a HCW has a parenteral (e.g., needlestick or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids, the source patient should be assessed clinically and epidemiologically to determine the likelihood of HTLV-III/LAV infection. If the assessment suggests that infection may exist, the patient should be informed of the incident and requested to consent to serologic testing for evidence of HTLV-III/LAV infection. If the source patient has AIDS or other evidence of HTLV-III/LAV infection, declines testing, or has a positive test, the HCW should be evaluated clinically and serologically for evidence of HTLV-III/LAV infection as soon as possible after the exposure, and, if seronegative, retested after 6 weeks and on a periodic basis thereafter (e.g., 3, 6, and 12 months following exposure) to determine if

HTLV-III/LAV – Continued

transmission has occurred. During this follow-up period, especially the first 6-12 weeks, when most infected persons are expected to seroconvert, exposed HCWs should receive counseling about the risk of infection and follow U.S. Public Health Service (PHS) recommendations for preventing transmission of AIDS (*20,21*). If the source patient is seronegative and has no other evidence of HTLV-III/LAV infection, no further follow-up of the HCW is necessary. If the source patient cannot be identified, decisions regarding appropriate follow-up should be individualized based on the type of exposure and the likelihood that the source patient was infected.

Serologic testing of patients. Routine serologic testing of all patients for antibody to HTLV-III/LAV is not recommended to prevent transmission of HTLV-III/LAV infection in the workplace. Results of such testing are unlikely to further reduce the risk of transmission, which, even with documented needlesticks, is already extremely low. Furthermore, the risk of needlestick and other parenteral exposures could be reduced by emphasizing and more consistently implementing routinely recommended infection-control precautions (e.g., not recapping needles). Moreover, results of routine serologic testing would not be available for

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TABLE I. Summary—cases of specified notifiable diseases, United States

Disease	45th Week Ending			Cumulative 45th Week Ending		
	Nov. 9, 1985	Nov. 10, 1984	Median 1980-1984	Nov. 9, 1985	Nov. 10, 1984	Median 1980-1984
Acquired Immunodeficiency Syndrome (AIDS)	205	67	N	6,897	3,643	N
Aseptic meningitis	252	148	215	8,712	7,078	8,272
Encephalitis: Primary (arthropod-borne & unspec.)	23	25	26	1,059	1,043	1,337
Post-infectious	-	2	1	107	103	81
Gonorrhea: Civilian	11,497	15,584	17,153	726,159	728,211	828,957
Military	369	498	580	15,869	18,630	22,977
Hepatitis: Type A	287	456	484	19,460	18,545	19,734
Type B	381	494	435	22,444	22,407	18,702
Non A, Non B	54	76	N	3,527	3,287	N
Unspecified	70	114	162	4,944	4,422	7,465
Legionellosis	9	13	N	562	602	N
Leprosy	3	-	3	304	195	195
Malaria	4	25	15	872	875	931
Measles: Total*	17	5	24	2,598	2,439	2,439
Indigenous	17	2	N	2,165	2,150	N
Imported	-	3	N	433	289	N
Meningococcal infections: Total	35	38	53	2,038	2,322	2,365
Civilian	35	38	52	2,034	2,318	2,350
Military	-	-	-	4	4	14
Mumps	37	48	70	2,541	2,565	3,884
Pertussis	70	35	35	2,761	2,069	1,525
Rubella (German measles)	7	8	15	580	670	1,899
Syphilis (Primary & Secondary): Civilian	313	581	581	21,970	24,199	26,766
Military	1	4	4	126	261	334
Toxic Shock syndrome	6	3	N	307	415	N
Tuberculosis	303	383	467	18,350	18,399	21,977
Tularemia	1	3	2	143	266	238
Typhoid fever	4	15	9	315	322	404
Typhus fever, tick-borne (RMSF)	5	12	6	660	801	1,072
Rabies, animal	64	99	99	4,624	4,753	5,514

TABLE II. Notifiable diseases of low frequency, United States

	Cum. 1985		Cum. 1985
Anthrax	-	Leptospirosis	32
Botulism: Foodborne	43	Plague	15
Infant	50	Poliomyelitis: Total	5
Other	1	Paralytic	5
Brucellosis (Ohio 1, Tex. 2)	119	Psittacosis (Mich. 1, Oreg. 1)	94
Cholera	3	Rabies, human	1
Congenital rubella syndrome	-	Tetanus (La. 1)	61
Congenital syphilis, ages < 1 year	149	Trichinosis (Tex. 1)	56
Diphtheria	1	Typhus fever, flea-borne (endemic, murine) (Md. 1)	21

*There were no cases of internationally imported measles reported for this week.

HTLV-III/LAV – Continued

emergency cases and patients with short lengths of stay, and additional tests to determine whether a positive test was a true or false positive would be required in populations with a low prevalence of infection. However, this recommendation is based only on considerations of occupational risks and should not be construed as a recommendation against other uses of the serologic test, such as for diagnosis or to facilitate medical management of patients. Since the experience with infected patients varies substantially among hospitals (75% of all AIDS cases have been reported by only 280 of the more than 6,000 acute-care hospitals in the United States), some hospitals in certain geographic areas may deem it appropriate to initiate serologic testing of patients.

TRANSMISSION FROM HEALTH-CARE WORKERS TO PATIENTS

Risk of transmission of HTLV-III/LAV infection from HCWs to patients. Although there is no evidence that HCWs infected with HTLV-III/LAV have transmitted infection to patients, a risk of transmission of HTLV-III/LAV infection from HCWs to patients would exist in situations where there is both (1) a high degree of trauma to the patient that would provide a portal of entry for the virus (e.g., during invasive procedures) and (2) access of blood or serous fluid from the infected HCW to the open tissue of a patient, as could occur if the HCW sustains a needlestick or scalpel injury during an invasive procedure. HCWs known to be infected with HTLV-III/LAV who do not perform invasive procedures need not be restricted from work unless they have evidence of other infection or illness for which any HCW should be restricted. Whether additional restrictions are indicated for HCWs who perform invasive procedures is currently being considered.

Precautions to prevent transmission of HTLV-III/LAV infection from HCWs to patients. These precautions apply to all HCWs, regardless of whether they perform invasive procedures: (1) All HCWs should wear gloves for direct contact with mucous membranes or nonintact skin of all patients and (2) HCWs who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.

Management of parenteral and mucous membrane exposures of patients. If a patient has a parenteral or mucous membrane exposure to blood or other body fluids of a HCW, the patient should be informed of the incident and the same procedure outlined above for exposures of HCWs to patients should be followed for both the source HCW and the potentially exposed patient. Management of this type of exposure will be addressed in more detail in the recommendations for HCWs who perform invasive procedures.

Serologic testing of HCWs. Routine serologic testing of HCWs who do not perform invasive procedures (including providers of home and prehospital emergency care) is not recommended to prevent transmission of HTLV-III/LAV infection. The risk of transmission is extremely low and can be further minimized when routinely recommended infection-control precautions are followed. However, serologic testing should be available to HCWs who may wish to know their HTLV-III/LAV infection status. Whether indications exist for serologic testing of HCWs who perform invasive procedures is currently being considered.

Risk of occupational acquisition of other infectious diseases by HCWs infected with HTLV-III/LAV. HCWs who are known to be infected with HTLV-III/LAV and who have defective immune systems are at increased risk of acquiring or experiencing serious complications of other infectious diseases. Of particular concern is the risk of severe infection following exposure to patients with infectious diseases that are easily transmitted if appropriate precautions are not taken (e.g., tuberculosis). HCWs infected with HTLV-III/LAV should be counseled about the potential risk associated with taking care of patients with transmissible infections and should continue to follow existing recommendations for infection control to minimize

HTLV-III/LAV – Continued

their risk of exposure to other infectious agents (*18,19*). The HCWs' personal physician(s), in conjunction with their institutions' personnel health services or medical directors, should determine on an individual basis whether the infected HCWs can adequately and safely perform patient-care duties and suggest changes in work assignments, if indicated. In making this determination, recommendations of the Immunization Practices Advisory Committee and institutional policies concerning requirements for vaccinating HCWs with live-virus vaccines should also be considered.

STERILIZATION, DISINFECTION, HOUSEKEEPING, AND WASTE DISPOSAL TO PREVENT TRANSMISSION OF HTLV-III/LAV

Sterilization and disinfection procedures currently recommended for use (*22,23*) in health-care and dental facilities are adequate to sterilize or disinfect instruments, devices, or other items contaminated with the blood or other body fluids from individuals infected with HTLV-III/LAV. Instruments or other nondisposable items that enter normally sterile tissue or the vascular system or through which blood flows should be sterilized before reuse. Surgical instruments used on all patients should be decontaminated after use rather than just rinsed with water. Decontamination can be accomplished by machine or by hand cleaning by trained personnel wearing appropriate protective attire (*24*) and using appropriate chemical germicides. Instruments or other nondisposable items that touch intact mucous membranes should receive high-level disinfection.

Several liquid chemical germicides commonly used in laboratories and health-care facilities have been shown to kill HTLV-III/LAV at concentrations much lower than are used in practice (*25*). When decontaminating instruments or medical devices, chemical germicides that are registered with and approved by the U.S. Environmental Protection Agency (EPA) as "sterilants" can be used either for sterilization or for high-level disinfection depending on contact time; germicides that are approved for use as "hospital disinfectants" and are mycobactericidal when used at appropriate dilutions can also be used for high-level disinfection of devices and instruments. Germicides that are mycobactericidal are preferred because mycobacteria represent one of the most resistant groups of microorganisms; therefore, germicides that are effective against mycobacteria are also effective against other bacterial and viral pathogens. When chemical germicides are used, instruments or devices to be sterilized or disinfected should be thoroughly cleaned before exposure to the germicide, and the manufacturer's instructions for use of the germicide should be followed.

Laundry and dishwashing cycles commonly used in hospitals are adequate to decontaminate linens, dishes, glassware, and utensils. When cleaning environmental surfaces, housekeeping procedures commonly used in hospitals are adequate; surfaces exposed to blood and body fluids should be cleaned with a detergent followed by decontamination using an EPA-approved hospital disinfectant that is mycobactericidal. Individuals cleaning up such spills should wear disposable gloves. Information on specific label claims of commercial germicides can be obtained by writing to the Disinfectants Branch, Office of Pesticides, Environmental Protection Agency, 401 M Street, S.W., Washington, D.C., 20460.

In addition to hospital disinfectants, a freshly prepared solution of sodium hypochlorite (household bleach) is an inexpensive and very effective germicide (*25*). Concentrations ranging from 5,000 ppm (a 1:10 dilution of household bleach) to 500 ppm (a 1:100 dilution) sodium hypochlorite are effective, depending on the amount of organic material (e.g., blood, mucus, etc.) present on the surface to be cleaned and disinfected.

Sharp items should be considered as potentially infective and should be handled and disposed of with extraordinary care to prevent accidental injuries. Other potentially infective waste should be contained and transported in clearly identified impervious plastic bags. If the

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outside of the bag is contaminated with blood or other body fluids, a second outer bag should be used. Recommended practices for disposal of infective waste (*23*) are adequate for disposal of waste contaminated by HTLV-III/LAV. Blood and other body fluids may be carefully poured down a drain connected to a sanitary sewer.

CONSIDERATIONS RELEVANT TO OTHER WORKERS

Personal-service workers (PSWs). PSWs are defined as individuals whose occupations involve close personal contact with clients (e.g., hairdressers, barbers, estheticians, cosmetologists, manicurists, pedicurists, massage therapists). PSWs whose services (tattooing, ear piercing, acupuncture, etc.) require needles or other instruments that penetrate the skin should follow precautions indicated for HCWs. Although there is no evidence of transmission of HTLV-III/LAV from clients to PSWs, from PSWs to clients, or between clients of PSWs, a risk of transmission would exist from PSWs to clients and vice versa in situations where there is both (1) trauma to one of the individuals that would provide a portal of entry for the virus and (2) access of blood or serous fluid from one infected person to the open tissue of the other, as could occur if either sustained a cut. A risk of transmission from client to client exists when instruments contaminated with blood are not sterilized or disinfected between clients. However, HBV transmission has been documented only rarely in acupuncture, ear piercing, and tattoo establishments and never in other personal-service settings, indicating that any risk for HTLV-III/LAV transmission in personal-service settings must be extremely low.

All PSWs should be educated about transmission of bloodborne infections, including HTLV-III/LAV and HBV. Such education should emphasize principles of good hygiene, antisepsis, and disinfection. This education can be accomplished by national or state professional organizations, with assistance from state and local health departments, using lectures at meetings or self-instructional materials. Licensure requirements should include evidence of such education. Instruments that are intended to penetrate the skin (e.g., tattooing and acupuncture needles, ear piercing devices) should be used once and disposed of or be thoroughly cleaned and sterilized after each use using procedures recommended for use in health-care institutions. Instruments not intended to penetrate the skin but which may become contaminated with blood (e.g., razors), should be used for only one client and be disposed of or thoroughly cleaned and disinfected after use using procedures recommended for use in health-care institutions. Any PSW with exudative lesions or weeping dermatitis, regardless of HTLV-III/LAV infection status, should refrain from direct contact with clients until the condition resolves. PSWs known to be infected with HTLV-III/LAV need not be restricted from work unless they have evidence of other infections or illnesses for which any PSW should also be restricted.

Routine serologic testing of PSWs for antibody to HTLV-III/LAV is not recommended to prevent transmission from PSWs to clients.

Food-service workers (FSWs). FSWs are defined as individuals whose occupations involve the preparation or serving of food or beverages (e.g., cooks, caterers, servers, waiters, bartenders, airline attendants). All epidemiologic and laboratory evidence indicates that bloodborne and sexually transmitted infections are not transmitted during the preparation or serving of food or beverages, and no instances of HBV or HTLV-III/LAV transmission have been documented in this setting.

All FSWs should follow recommended standards and practices of good personal hygiene and food sanitation (*26*). All FSWs should exercise care to avoid injury to hands when preparing food. Should such an injury occur, both aesthetic and sanitary considerations would dictate that food contaminated with blood be discarded. FSWs known to be infected with HTLV-III/LAV need not be restricted from work unless they have evidence of other infection or illness for which any FSW should also be restricted.

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Routine serologic testing of FSWs for antibody to HTLV-III/LAV is not recommended to prevent disease transmission from FSWs to consumers.

Other workers sharing the same work environment. No known risk of transmission to co-workers, clients, or consumers exists from HTLV-III/LAV-infected workers in other settings (e.g., offices, schools, factories, construction sites). This infection is spread by sexual contact with infected persons, injection of contaminated blood or blood products, and by perinatal transmission. Workers known to be infected with HTLV-III/LAV should not be restricted from work solely based on this finding. Moreover, they should not be restricted from using telephones, office equipment, toilets, showers, eating facilities, and water fountains. Equipment contaminated with blood or other body fluids of any worker, regardless of HTLV-III/LAV infection status, should be cleaned with soap and water or a detergent. A disinfectant solution or a fresh solution of sodium hypochlorite (household bleach, see above) should be used to wipe the area after cleaning.

OTHER ISSUES IN THE WORKPLACE

The information and recommendations contained in this document do not address all the potential issues that may have to be considered when making specific employment decisions for persons with HTLV-III/LAV infection. The diagnosis of HTLV-III/LAV infection may evoke unwarranted fear and suspicion in some co-workers. Other issues that may be considered include the need for confidentiality, applicable federal, state, or local laws governing occupational safety and health, civil rights of employees, workers' compensation laws, provisions of collective bargaining agreements, confidentiality of medical records, informed consent, employee and patient privacy rights, and employee right-to-know statutes.

DEVELOPMENT OF THESE RECOMMENDATIONS

The information and recommendations contained in these recommendations were developed and compiled by CDC and other PHS agencies in consultation with individuals representing various organizations. The following organizations were represented: Association of State and Territorial Health Officials, Conference of State and Territorial Epidemiologists, Association of State and Territorial Public Health Laboratory Directors, National Association of County Health Officials, American Hospital Association, United States Conference of Local Health Officers, Association for Practitioners in Infection Control, Society of Hospital Epidemiologists of America, American Dental Association, American Medical Association, American Nurses' Association, American Association of Medical Colleges, American Association of Dental Schools, National Institutes of Health, Food and Drug Administration, Food Research Institute, National Restaurant Association, National Hairdressers and Cosmetologists Association, National Gay Task Force, National Funeral Directors and Morticians Association, American Association of Physicians for Human Rights, and National Association of Emergency Medical Technicians. The consultants also included a labor union representative, an attorney, a corporate medical director, and a pathologist. However, these recommendations may not reflect the views of individual consultants or the organizations they represented.

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GUIDELINES FOR CHILDREN WITH AIDS/ARC ATTENDING SCHOOL
Indiana State Board of Health--July 1985

The Acquired Immunodeficiency Syndrome (AIDS) is a very serious disorder caused by infections with Human T-Cell Lymphotropic Virus Type III (HTLV-III). Persons with AIDS have developed, as a result of their HTLV-III infection, a defect in the functioning of their immune system. This makes them extremely susceptible to certain types of opportunistic infections and to certain rare malignancies. No treatment is currently available to reverse the underlying immune system deficiency, and at the present time there is no vaccine to prevent the disease.

To meet the definition of AIDS, an individual must be diagnosed as having an opportunistic infection such as Pneumocystis carinii pneumonia, or a specific rare malignancy such as Kaposi's sarcoma (see Appendix 1). However, not all persons infected with HTLV-III virus develop severe full-blown AIDS. In some, the infection leads to detectable, but apparently less severe, abnormalities of the immune system that do not result in the development of an opportunistic infection or malignancies listed in Appendix 1. This condition is called the AIDS-related complex or ARC (see Appendix 2). Some individuals with ARC will go on to develop AIDS, although the exact percentage is not known. Since ARC patients are infected with HTLV-III virus, they may be capable of transmitting the infection to others. Thus the same precautions to prevent spread of HTLV-III infection apply to both AIDS and ARC patients.

Persons at increased risk for AIDS/ARC include homosexual or bisexual men, abusers of intravenous drugs, Haitian entrants to the U.S., patients with hemophilia, and sexual partners of persons infected with HTLV-III virus. In addition, a relatively small number of cases have been seen in blood transfusion recipients, and some infants have acquired the disease from their infected mothers before or at the time of birth. HTLV-III virus has been found in blood, seminal fluid, and saliva of AIDS patients. It can be transmitted from one person to another in several ways, but each way seems to involve either direct inoculation or introduction of an infectious body fluid from the infected person to another individual. This inoculation or introduction can, for example, occur by intimate sexual contact, sharing of hypodermic needles, blood transfusions, or transmission from mother to infant before or at the time of birth. No evidence exists to support transmission of the disease by casual contact or by the airborne route. There have been no documented instances of health care workers acquiring AIDS through contact with AIDS/ARC patients. All evidence regarding the transmission of AIDS indicates that the type of contact between persons which normally occurs in a school setting should not result in the transmission of the AIDS virus.

An issue that an increasing number of schools will be facing is what to do regarding children with AIDS or ARC. Should these children be allowed to attend school, and if so, what precautions would be needed to protect other students and staff? To assist school officials and local health departments in dealing with this matter, the Indiana State Board of Health presents the following set of guidelines*:

1. AIDS/ARC children should be allowed to attend school as long as they behave acceptably (e.g., do not bite, are toilet-trained), and have no uncoverable sores or skin eruptions.

2. The parents should be advised that the child cannot attend school when he/she is acutely ill and/or has a fever, cough (respiratory illness), or diarrhea. If the child presents at school with these symptoms, he/she should be temporarily removed from the school setting.

3. A child with AIDS/ARC (as with any other immunodeficient child) may need to be removed from the classroom for his/her own protection when cases of measles or chickenpox are occurring in the school population. This decision should be made by the child's physician in consultation with the school nurse and/or the school medical advisor. There must be someone (for example, a school nurse) responsible for monitoring which diseases are occurring in the school, and aware of which children should be removed for their own protection if diseases such as measles or chickenpox occur.

4. Routine and standard procedures should be used to clean up after a child has an accident or injury at school. Blood or other body fluids emanating from a child with AIDS/ARC should be treated cautiously. Gloves should be worn when cleaning up blood spills. These "spills" should be disinfected with bleach or another disinfectant, and persons coming in contact with them should wash their hands afterwards. Blood soaked items should be placed in leakproof bags for washing or further disposition. Similar procedures are recommended for dealing with vomitus and fecal or urinary incontinence in an AIDS/ARC child. Materials such as gloves, bleach, and leakproof bags should be readily available. Staff who may have contact with the AIDS/ARC child, and/or his or her body fluids, should be knowledgeable about AIDS/ARC, how it is transmitted, and what to do if "spills" occur. Handwashing after contact with a school child is routinely recommended only if physical contact has been made with the child's blood or body fluids, including saliva.

5. The school should be informed that the child has AIDS/ARC. Selected persons within the school should have knowledge of the child's condition, including the principal, the school

nurse, and the child's classroom teacher. These persons should be provided with appropriate information concerning such precautions as may be necessary, and they should be aware of confidentiality requirements. Specifically, the school should respect the right to privacy of the individual.

6. School officials, the child's physician, local public health officials, and the child's parents should work together in dealing with the issues which will arise regarding the child's attendance at school.

   A school nurse, medical social worker, or other person should be appointed as the child's advocate to assist in problems that may arise, serve as a liaison with the child's physician, provide educational materials, be a focal point for questions, and constitute an impartial party with whom all sides can relate.

7. The local health department should have a contact person knowledgeable about AIDS for the advocate or others with questions.

8. Each removal of a child with AIDS/ARC from normal school attendance should be reviewed by the school medical advisor and/or the school nurse in consultation with the student's physician at least once every month to determine whether the condition precipitating the removal has changed.

9. The Indiana State Board of Health Executive Board has formed an Advisory Committee on AIDS/ARC. These guidelines will be reviewed and updated by that committee as necessary.

*These guidelines were excerpted and adapted from guidelines and recommendations developed in Florida and Connecticut.

APPENDIX 1
DEFINITION OF AIDS

Until June 1985, the diagnosis of AIDS did not take into account the results of any laboratory tests, but rather relied totally on clinical findings. Specifically, for a person to be diagnosed as having AIDS, they had to have a reliably diagnosed disease that was at least moderately indicative of an underlying cellular immunodeficiency, and they had to have no known cause of underlying cellular immunodeficiency or any other reduced resistance reported to be associated with that disease.

These diagnostic criteria were made more explicit by specifying:

I. The particular diseases considered at least moderately indicative of cellular immune deficiency, and

II. The known causes of cellular immune deficiency, or other causes of reduced resistance reported to be associated with particular diseases.

I. Diseases strongly suggestive of underlying Cellular Immune Deficiency:

These are listed below in 5 etiological categories: A. protozoal and helminthic, B. fungal, C. bacterial, D. viral, and E. cancer. Within each category, the diseases are listed in alphabetical order. "Disseminated infection" refers to involvement of liver, bone marrow, or multiple organs, not simply involvement of lungs and multiple lymph nodes. The required diagnostic methods with positive results are shown in parentheses.

A. Protozoal and Helminthic Infections:

1. Cryptosporidiosis, intestinal, causing diarrhea for over 1 month, (on histology or stool microscopy)

2. Pneumocystis carinii pneumonia, (on histology, or microscopy of a "touch" preparation or bronchial washings)

3. Strongyloidosis, causing pneumonia, central nervous system infection, or disseminated infection, (on histology)

4. Toxoplasmosis, causing pneumonia or central nervous system infection (on histology or microscopy of a "touch" preparation)

B. Fungal Infections:

1. Aspergillosis, causing central nervous system or disseminated infection (on culture or histology)

2. Candidiasis, causing esophagitis (on histology, or microscopy of a "wet" preparation from the esophagus, or endoscopic findings of white plaques on an erythematous mucosal base)

3. Cryptococcosis, causing pulmonary, central nervous system or disseminated infection (on culture, antigen detection, histology, or India ink preparation of CSF)

C. Bacterial Infections:

1. "Atypical" mycobacteriosis (species other than tuberculosis or leprae), causing disseminated infection (on culture)

D. Viral Infections:

1. Cytomegalovirus, causing pulmonary, gastrointestinal tract, or central nervous system infection (on histology)

2. Herpes simplex virus, causing chronic mucocutaneous infection with ulcers persisting more than 1 month, or pulmonary, gastrointestinal tract, or disseminated infection (on culture, histology, or cytology)

3. Progressive multifocal leukoencephalopathy (presumed to be caused by Papovavirus) (on histology)

E. Cancer:

1. Kaposi's sarcoma (on histology)

2. Lymphoma limited to the brain (on histology)

II. Known Causes of Reduced Resistance

Known causes of reduced resistance to diseases suggestive of immune deficiency are listed in the left column, while the diseases that may be attributable to these causes (rather than to the immune deficiency of AIDS) are listed on the right:

Known Causes of Reduced Resistance	Diseases Possibly Attributable to the Known Causes of Reduced Resistance
1. Systemic corticosteroid or other immunosuppressive or cytotoxic therapy	Any infection that began during or within 1 month after such therapy, if the therapy began before signs or symptoms specific for the infected anatomic sites (e.g., dyspnea for pneumonia, headache for encephalitis, diarrhea for colitis); or cancer diagnosed during or within 1 month after more than 4 months of such therapy if the therapy began before signs or symptoms specific for the anatomic sites of the cancer.

2.	Widely spread cancer of lymphoid or histiocytic tissue, such as lymphoma, Hodgkin's disease, lymphocytic leukemia, or multiple myeloma; (this does not include cancer that is entirely localized to one site, such as primary lymphoma of the brain).	Any other cancer or infection, regardless, of whether diagnosed before or after (because a lymphoma may have been present before, even if diagnosed after)
3.	Age 60 years or older at diagnosis	Kaposi's sarcoma
4.	Age under 28 days (neonatal) at diagnosis	Toxoplasmosis, cytomegalovirus, herpes simplex virus infections
5.	An immune deficiency atypical of AIDS, such as one involving hypogammaglobulinemia; or an immune deficiency of which the cause appears to be a genetic or developmental defect (e.g., thymic dysplasia)	Any infection or cancer diagnosed such immune deficiency

The provisional case definition of AIDS in children (less than 13 years old) was the following:

For the limited purposes of epidemiologic surveillance, CDC defines a case of pediatric acquired immunodeficiency syndrome (AIDS) as a child who has had:

1. a reliably diagnosed disease at least moderately indicative of underlying cellular immunodeficiency and
2. no known cause of underlying cellular immunodeficiency or any other reduced resistance reported to be associated with that disease.

The diseases accepted as sufficiently indicative of underlying cellular immunodeficiency are the same as those used in defining AIDS in adults (*1*) with the exclusion of congenital infections, e.g., toxoplasmosis or herpes simplex virus infection in the first month after birth or cytomegalovirus infection in the first 6 months after birth.

Specific conditions that must be excluded in a child are:

1. Primary immunodeficiency diseases—severe combined immunodeficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome, ataxia-telangiectasia, graft versus host disease, neutropenia, neutrophil function abnormality, agammaglobulinemia, or hypogammaglobulinemia with raised IgM.*
2. Secondary immunodeficiency associated with immunosuppressive therapy, lymphoreticular malignancy, or starvation.

*Immunodeficiency. WHO Technical Report Series 1978;630 28-31.

In June 1985, CDC refined the case definition of AIDS as follows:

a. In the absence of the opportunistic diseases required by the current case definition, any of the following diseases will be considered indicative of AIDS if the patient has a positive serologic or virologic test for HTLV-III/LAV:
   (1) disseminated histoplasmosis (not confined to lungs or lymph nodes), diagnosed by culture, histology, or antigen detection;
   (2) isosporiasis, causing chronic diarrhea (over 1 month), diagnosed by histology or stool microscopy;
   (3) bronchial or pulmonary candidiasis, diagnosed by microscopy or by presence of characteristic white plaques grossly on the bronchial mucosa (not by culture alone);
   (4) non-Hodgkin's lymphoma of high-grade pathologic type (diffuse, undifferentiated) and of B-cell or unknown immunologic phenotype, diagnosed by biopsy;
   (5) histologically confirmed Kaposi's sarcoma in patients who are 60 years old or older when diagnosed.
b. In the absence of the opportunistic diseases required by the current case definition, a histologically confirmed diagnosis of chronic lymphoid interstitial pneumonitis in a child (under 13 years of age) will be considered indicative of AIDS unless test(s) for HTLV-III/LAV are negative.
c. Patients who have a lymphoreticular malignancy diagnosed more than 3 months after the diagnosis of an opportunistic disease used as a marker for AIDS will no longer be excluded as AIDS cases.
d. To increase the specificity of the case definition, patients will be excluded as AIDS cases if they have a negative result on testing for serum antibody to HTLV-III/LAV, have no other type of HTLV-III/LAV test with a positive result, and do not have a low number of T-helper lymphocytes or a low ratio of T-helper to T-suppressor lymphocytes. In the absence of test results, patients satisfying all other criteria in the definition will continue to be included.

APPENDIX 2
DEFINITION OF AIDS-RELATED COMPLEX

At least 2 of the following clinical signs/symptoms lasting 3 or more months PLUS 2 or more of the following laboratory abnormalities, occurring in a patient having no underlying infectious cause for the symptoms and who is in a cohort at increased risk for developing AIDS.

Clinical:

1) Fever: $\geq 100^{\circ}$ F, intermittent or continuous, for at least 3 months, in the absence of other identifiable causes.

2) Weight Loss: $\geq$ 10% or $\geq$15 lbs.

3. Lymphadenopathy: persistent for at least 3 months, involving 2 extra-inguinal node bearing areas.

4. Diarrhea: intermittent or continuous, $\geq$3 months, in the absence of other identifiable causes.

5. Fatigue, to the point of decreased physical or mental function.

6. Night Sweats: intermittent or continuous, $\geq$3 months, in the absence of other identifiable causes.

Laboratory:

1) Depressed helper T-cells. ($\geq$2 standard deviations below mean).

2) Depressed helper/suppressor ratio. ($\geq$2 standard deviations below mean).

3) At least one of the following: leukopenia, thrombocytopenia, absolute lymphopenia or anemia.

4) Elevated serum globulins.

5) Depressed blastogenesis (pokeweed and PHA).

6) Abnormal skin tests (using Multi-Test or equivalent).

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